

BULLETIN

AMERICAN COLLEGE OF SURGEONS



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Clinical Congress 2001 Highlights

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Front cover design

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About the cover...

This month's cover depicts highlights of the 2001 Clinical Congress, including (clockwise from upper left): presentation of the Distinguished Service Award; the Presidential Address delivered by R. Scott Jones, MD, FACS; a special session on terrorism; the presentation of the National Safety Council's Surgeons Award for Service to Safety and the College's Distinguished Philanthropist Award; the carrying of the Great Mace during the Convocation; the dedication of the Owen H. Wangensteen Surgical Forum; and Dr. Jones's installation as President (center). Details about these and other events during the Clinical Congress are offered on page 21. (Photos by Chuck Giorno Photography.)

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From my perspective

On October 23, I met with Tom Scully in his offices at the U.S. Department of Health and Human Services. As you probably know, Mr. Scully is the new Administrator of the Centers for Medicare & Medicaid Services (CMS), previously known as the Health Care Financing Administration. With me was Cindy Brown, Director of the College's Division of Advocacy and Health Policy. Ken Simon, MD, FACS, a general surgeon who works for the CMS, was also in attendance. Our conversation centered largely on the steep reductions in Medicare payment all physicians are likely to face in January 2002 and on the regulatory burdens they are dealing with.

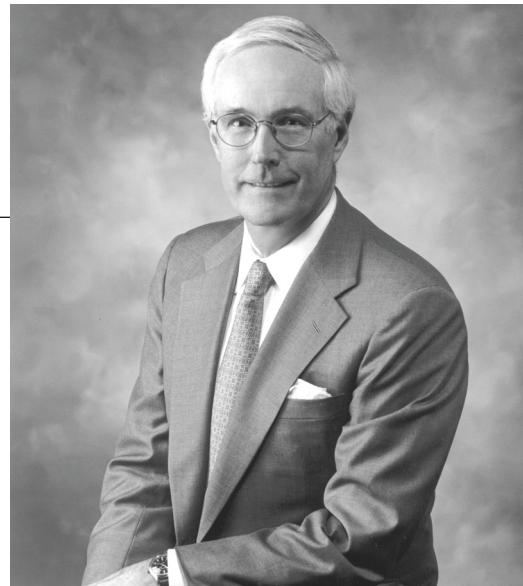
I found Mr. Scully to be very knowledgeable with respect to the controversies surrounding the issue of physician reimbursement. He clearly understands the overriding problem, which is a flaw in the law that established the current basis for setting the conversion factor that determines Medicare payment.

We noted that these Medicare reductions are occurring at the same time that surgeons and other physicians are encountering heightened regulatory and legal burdens. We explained to Mr. Scully that new laws and rules dealing with compliance, emergency room coverage, and so on, place increasing pressures on a surgeon's practice and responsibility. Rising liability costs add further financial strains. These factors, coupled with falling reimbursement, are simply making practice untenable for many surgeons and other physicians. Mr. Scully recognizes that our concerns are very real, having witnessed the experience of a close friend who is a surgeon and who retired from practice at age 51 for all of these reasons.

One meeting with the CMS Administrator, however, is obviously not going to be enough to stem the tide of financial burdens that are likely to wash over surgeons' practices during the coming months. The entire surgical and medical community must be involved in efforts to achieve some relief. I'd like to take this opportunity to inform all of you about the potential problems and to suggest some approaches to preventing them.

Inequities of the system

As I have communicated previously, our General Surgery Coding and Reimbursement Committee really made significant strides this year in increas-



“The College has joined a coalition of more than 50 medical organizations to vehemently protest the reduction in a conversion factor that is based on unsound legislation...”

ing the work values for more than 240 surgical services. This effort would have culminated in significant increases in reimbursement for many procedures. Unfortunately, much of their achievement will be undone by CMS's recent announcement that there will be a 5.4 percent reduction in the fee schedule conversion factor for 2002, bringing payment per relative value unit down from \$38.26 to \$36.19. This reduction will become effective January 1, 2002, unless Congress intervenes.

As Mr. Scully correctly points out, the CMS reduced the conversion factor because of legislation passed during the previous Administration. The law is flawed because it bases the annual conversion factor update on a “sustainable growth rate” that is tied to the business cycle rather than to health care costs. This formula creates overall restrictions on aggregate Medicare spending and continues to apply faulty 1998 and 1999 data that have unfairly removed billions of dollars from the permitted spending target. Recognizing the problem, Congress passed and former President Clinton

signed legislation in 1999 that attempted to suture some of the cuts in payment but did not change most of the inherent flaws in the sustainable growth rate formula. As a result, we now face this 5.4 percent reduction in Medicare payment for 2002.

Congress has attempted to build allowances for technological improvements into other payment systems; however, the target for physicians and other health care practitioners is not adjusted for technological improvements. At the same time, Medicare Part B spending increased the past year by approximately 13 percent, largely due to the introduction of new drugs and medical devices, many of which are very costly. As spending for these items consumes more Part B dollars, physicians and other health care professionals are expected to accept a corresponding reduction in their payments. I pointed out to Mr. Scully that this policy is unfair to surgeons and other health care providers who are in the “trenches” delivering care, especially given the regulatory burdens mentioned previously and a Medicare reimbursement formula that is based on a skewed conversion factor.

What we can do

What can the American College of Surgeons and you as individual surgeons do to resolve, or at least curtail, these problems? First, the entire surgical and medical community must come together and speak with a unified voice. To that end, the College has joined a coalition of more than 50 medical organizations to vehemently protest the reduction in a conversion factor that is based on unsound legislation and that ties the target to economic indicators. As a large coalition, we will be forceful in expressing our dismay and concern with the fourth major reduction in reimbursement for physicians and surgeons in the last 10 years. Specific actions we are taking and in which I encourage each of you to participate are as follows:

- We are urging Congress to pass the Medicare Physician Payment Fairness Act of 2001, which was introduced on November 8, 2001, by Sens. Jim Jeffords (I-VT) and John Breaux (D-LA). If passed by Congress before the end of the year, this legislation would significantly reduce the negative 5.4 percent Medicare physician payment update scheduled to take effect January 1, 2002, under next year's Medicare physician fee schedule. The bill

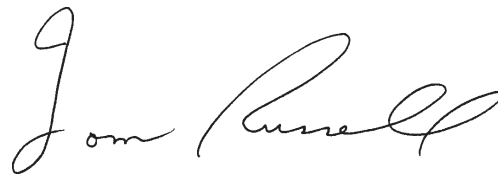
would legislate a negative 0.9 percent payment update for the 2002 fee schedule conversion factor, setting aside the scheduled 4.8 percent reduction tied to physician spending under the sustainable growth rate.

- We will continue to point out to the legislators that a major and unacceptable flaw in the system is that the target is tied to the business cycle and not to the need of patients.

- We will continue to assert to the legislators that it is unfair to have the physician portion of Part B compete with the rapidly escalating costs of the pharmaceutical and the medical device industries. Under this system, when the target is exceeded, physicians and other providers must absorb the increase in expenditure.

- **As many surgeons as possible need to contact their legislators via telephone and e-mail to express their concerns about the egregiousness of the 5.4 percent reduction in the conversion factor. (Access the College's Legislative Action Center at <http://capwiz.com/facs/issues/alert/?alertid=63328> to e-mail a letter to Capitol Hill or contact your legislator through the Capitol Hill switchboard at 202/224-3121.)** This decrease not only will affect the financial viability of physicians' and surgeons' practices—it will adversely affect access to care for Medicare patients and further slash the safety net for the uninsured. Furthermore, continued cuts in reimbursement and regulations leading to increased office expenses will simply lead to early retirement for many surgeons and will definitely make it more difficult for the profession to attract surgeons in the future.

This is a time when we all need to come together as organizations and as individuals to vociferously and effectively state our case. Your support and action, as well as suggestions, are needed at this time.



Thomas R. Russell, MD, FACS

If you have comments or suggestions about this or other issues, please send them to Dr. Russell at fmp@facs.org.

FYI: *STAT*

This column provides brief reports on important items of interest to members of the College. It will appear in the Bulletin when there is "hot news" to report. In-depth coverage of activities announced here will appear in columns and features published in the Bulletin and in the College's weekly electronic newsletter, ACS NewsScope.

❖ On October 23, ACS Executive Director Thomas R. Russell, MD, FACS, and Cynthia Brown, Director of the College's Division of Advocacy and Health Policy, met with key individuals at the **Centers for Medicare & Medicaid Services (CMS)**, the **National Committee for Quality Assurance (NCQA)**, and the **Leapfrog Group**. During the meeting with CMS Administrator Tom Scully, Dr. Russell outlined the College's concerns about the significant negative payment update for physician services included in next year's Medicare fee schedule. At the NCQA meeting with President Peggy O'Kane, Dr. Russell provided an overview of the College's long record, strong leadership, and current endeavors in promoting quality surgical care. Finally, Dr. Russell and Ms. Brown met with Suzanne Delblanco, PhD, Executive Director of the Leapfrog Group—a consortium of Fortune 500 companies and other large health care purchasers that was formed to mobilize employer purchasing power to improve patient safety and health care quality. Dr. Russell informed Dr. Delblanco about the College's concerns regarding different aspects and quality assumptions of regionalized care—a pillar of the Leapfrog Group's efforts for improving patient care.

❖ The **11th Surgical Education and Self-Assessment Program (SESAP 11)**, the all-new version of the College's classic home-study course, is now available. Since 1971, SESAP has helped surgeons to maintain and improve surgical proficiency, stay abreast of the latest cognitive and technological advances, and prepare for certification or recertification. SESAP consists of 650 multiple choice items in 17 subject categories with discussions and references. Materials are provided in both book and CD-ROM formats, and participants are eligible to earn up to 60 hours of Category 1 CME credit. To order, call 800/251-3775, fax 312/202-5005, or e-mail mlux@facs.org.

❖ According to the Journal Citation Reports for the year 2000, the ***Journal of the American College of Surgeons*** now ranks 11th of 136 in the category of surgery journals; in 1995, it ranked 34th. Its "impact factor"—the number of times a journal is cited by authors published in other journals—rose from 0.735 in 1995 to 2.805 in 2000.

❖ A CD-ROM containing **select postgraduate course syllabi from the 2001 Clinical Congress** is now available for purchase through the College's Web site at: <https://secure.telusys.net/commerce/current.html>, or by calling ACS Customer Service at 312/202-5474. The CD-ROM contains syllabi from 20 postgraduate courses and is available for \$35, with an additional charge of \$12 for shipping and handling for international orders. For further information, contact dpagels@facs.org.

Dateline Washington

prepared by the Division of Advocacy and Health Policy

CMS publishes rule on 2002 Medicare fee schedule

The Centers for Medicare & Medicaid Services (CMS) published the final rule for the 2002 Medicare physician fee schedule on November 1. The regulation includes a 5.4 percent across-the-board cut in payments for all physician services next year—lowering the dollar conversion factor from its current level of \$38.26 down to \$36.20.

The majority of the reduction for next year—4.8 percentage points—is the result of a congressionally mandated expenditure target formula for physician services known as the sustainable growth rate (SGR). This formula sets a target rate of spending growth for physician expenditures that is tied to a number of factors, including growth in the gross domestic product. CMS cites the slowing economy and a relatively high growth rate in physician spending under Medicare as the cause of the negative payment update.

In addition, the agency has incorporated a -0.6 percent reduction into next year's update to offset increased physician work values resulting from the second five-year review of this fee schedule component. Also factored into this number is a slight reduction to account for a "behavioral offset"—an anticipated increase in volume and intensity of physician services to offset losses due to the final year of the implementation of the new resource-based practice expense values. CMS is mandated to make these annual adjustments to the conversion factor in the event that policy or Medicare coverage decisions would increase aggregate spending for physician services under the fee schedule by more than \$20 million.

Breakdown of 5.4 percent payment cut

2001 conversion factor	\$38.26
2002 update resulting from SGR	-4.8 percent
Budget neutrality adjustment to account for increased work values from the 5-year review	-.46 percent
Budget neutrality adjustment to account for anticipated increase in services due to practice expense transition	-.18 percent
Total percentage reduction	- 5.44 percent
2002 conversion factor	\$36.20

While a small increase has been factored into the 2002 values for physician work for a number of general surgery codes, many of these gains were, unfortunately, offset by the 5.4 percent reduction to next year's conversion factor. As a result, payments for many general surgery procedures will remain flat for 2002.

Finally, the proposed rule on the 2002 fee schedule addressed a controversial issue revolving around inclusion of critical care in the valuation of certain procedure codes (in which critical care is a routine part of the postoperative care). CMS questioned whether Medicare might be making duplicate payments for critical care—once to the surgeon and once to another physician assigned to the intensive care unit. The agency made clear that it will not change Medicare's critical care payment policy in 2002, but asked for comments on various changes that could be made for 2003. The College objected strongly to all the proposed changes be-

House committee approves regulatory reform bill

College awarded AHRQ patient safety grants

cause they would violate the College's ethical standards on postoperative care, as well as Medicare's own global surgery policy. In the final rule, CMS noted the concerns of the College and numerous other health care groups and has indicated that it will carefully review these comments as it determines whether to make a future proposal on this issue.

At press time, Sens. Jim Jeffords (I-VT) and John Breaux (D-LA) had introduced the Medicare Physician Payment Fairness Act of 2001. If passed by Congress before the end of the year, this legislation would significantly reduce the negative 5.4 percent Medicare physician payment update scheduled to take effect January 1, 2002, under next year's Medicare physician fee schedule. The bill would legislate a negative 0.9 percent payment update for the 2002 fee schedule conversion factor, setting aside the scheduled 4.8 percent reduction tied to physician spending under the SGR. The Jeffords/Breaux proposal also mandates that the Medicare Payment Advisory Commission (MedPAC) conduct a study on replacing the SGR as a factor used to determine the physician payment update. The results of this study and MedPAC's recommendations for a substitute update formula would be presented to Congress by March 1, 2002.

On October 31, the House Energy and Commerce Committee approved H.R. 3046, the Medicare Regulatory, Appeals, Contracting, and Education Reform Act (Medicare RACER Act). Similar legislation was approved by the House Ways and Means Committee on October 11. Both bills address a number of serious problems with the claims auditing and overpayment recovery process. For example, both bills enhance physician due process rights, limit the use of extrapolation by Medicare contractors, and call for increased physician education on the part of Medicare contractors. The Medicare RACER Act also includes requirements not found in the Ways and Means bill, such as mandates that contractors provide general written guidance to physicians regarding billing and coding questions. Currently, the College is working with the American Medical Association and other physician groups to generate support for the strongest reform package possible.

Department of Health and Human Services Secretary Tommy Thompson announced on October 11 that the Agency for Healthcare Research and Quality (AHRQ) released \$50 million to fund 94 new research grants, contracts, and other projects to reduce medical errors and improve patient safety. The College was awarded three grants as part of this initiative. The first of these grants will fund a collaboration between the Veterans Administration (VA) and the College to evaluate the VA's National Surgical Quality Improvement Program as a reporting system to improve patient safety in surgery in both VA and non-federal hospitals. The second grant is for research to study the impact that a variety of factors could have on the safety of surgical care, including stress, organizational culture, teamwork, and working hours. The final grant will allow the College to modify existing educational programs to emphasize patient safety and initiatives to reduce surgical errors.



A review of the Presidential Address

Medicine, government, and capitalism

Editor's note: The following is a summary of the Presidential Address delivered by newly installed ACS President R. Scott Jones, MD, FACS. Dr. Jones' address was presented during the Convocation ceremonies at the 2001 Clinical Congress in New Orleans, LA, to an audience of approximately 2,000 meeting attendees—including Initiates, other Fellows, College Officers, and College staff.

The text of Dr. Jones' Presidential Address will appear in its entirety in the February 2002 issue of the Journal of the American College of Surgeons.

The surgical profession has continuously evolved, and the changes that have occurred over the last few decades, in particular, have produced "significant tension for our profession. That is not surprising, because progress and improvement will not occur without conflict," R. Scott Jones, MD, FACS, the newly installed President of the College, said during his Presidential Address at the 2001 Clinical Congress.

Dr. Jones explained how the internal and external conflicts between members of the medical profession and the government, insurers, and other stakeholders in the system have emerged and what surgeons can do to enhance patient care in the future. He began with a brief overview of the socioeconomic and political history of surgery and organized medicine in the U.S.

During the seventeenth century, "medical practitioners were either self-taught or learned through apprenticeship. There were no medical schools, medical societies, hospitals, or medical licensure," Dr. Jones said. However, the first law concerning the practice of medicine in the English Colonies was enacted in the Virginia Assembly in 1639. Ironically, given the current concerns about reimbursement, the purpose of that legislation was to control costs by regulating physicians' fees.

Virginia, New York, and New Jersey went on to pass licensing laws during the eighteenth century. Also during the 1700s, the first medical societies were formed, the first colonial hospital was opened, and the first U.S. medical school was established, Dr. Jones said.

After the Civil War, all states began to address the issues of licensure and medical education. Additionally, tremendous scientific advances in pathology, drug development, radiology, anesthesia, and surgical practice occurred in the nineteenth century. "Despite these changes, doctors, among those with education, generally had low status, low earnings, and little power," Dr. Jones said. To respond to these problems and to increase physicians' strength, the American Medical Association (AMA) and specialty societies surfaced.

Nonetheless, the greatest advances in organized medicine occurred during the twentieth century, largely because the provision of health care and payment for related services had grown increasingly complicated. The first private health insurance program was initiated in 1929 at Baylor Uni-

versity Hospital in Dallas, TX, and despite firm opposition from the AMA, prepaid health plans similar to today's health maintenance organization (HMOs) started in the early 1940s.

"Following World War II, the federal government again turned attention to health care when the Truman Administration advocated national health insurance," Dr. Jones said. Further, the federal government supported medicine with large infusions of money and program support that continue today, Dr. Jones said, pointing to funding for medical research, mental health programs, the Veterans Administration, and community hospital construction. "Perhaps the most significant event in health care in the United States occurred on July 30, 1965, when President Lyndon Johnson signed into law the legislation to introduce Medicare and Medicaid," Dr. Jones added.

The cost of health care continued to rise significantly throughout the 1960s, though, and in 1971, President Richard Nixon imposed wage and price controls, limiting increases in physicians' fees and hospital charges, Dr. Jones said. Caps on payment increases would continue throughout the remainder of the twentieth century with the development of prospective payment systems and managed care.

As we embark upon the twenty-first century, Dr. Jones observed, "Certainly cost remains the point of focus, particularly for government, the corporate sector, the public, and the medical profession, but the quality of health care demands additional attention."

Dr. Jones noted that the Institute of Medicine's Committee on Quality of Health Care in America recently published a report, *Crossing the Quality Chasm: A New Health System for the 21st Century*. He said the report lists four underlying reasons for inadequate quality of care: (1) the growing complexity of science and technology; (2) the increase in chronic conditions experienced by a population that is living longer; (3) a health care system that is "generally fragmented, poorly organized, and uncoordinated"; and (4) constraints on the revolution in information technology. The report asserts that "health care should be safe, effective, patient-centered, timely, efficient, and equitable," Dr. Jones added.

Dr. Jones said surgeons can actively respond to these points, particularly if organizations such as the American College of Surgeons emphasize four

areas of concern: (1) responsiveness to all stakeholders in the health system, including nonsurgeon practitioners, the government, the health insurance industry, and purchasers of care; (2) continued dissemination of information through meetings, the *Journal of the American College of Surgeons*, and electronic means; (3) expanded support of clinical trials and other methods that will help to contribute to evidence-based practice; and (4) the facilitation of quality control.

Guiding all these efforts should be a firm commitment to ethics. "The simmering of medicine, government, and the corporate sector in the broth of the trillion-dollar [health care] economy at some point will involve discussions of self-interest versus the interests of others, or altruism," Dr. Jones said.

Quoting from medical ethicist Albert Jonson, Dr. Jones defined self-interest as promoting "for oneself the values of preservation, growth, and happiness" and altruism as promoting "the preservation, growth, and happiness of other persons even to the detriment of one's own interest." He added that "altruism and self-interest coexist in all moral lives. They have a reciprocal relationship that varies from time to time and from circumstance to circumstance." Those individuals entering the surgical profession "would be well-served by a better than average endowment of altruism," Dr. Jones said.

The ability to look beyond one's self-interest will be a particularly important attribute to have as the profession readies itself for the ongoing debates over quality and the health care system in general. "When we engage in dialog with payors, government workers, corporate representatives, managers, [and so on] about patient-related matters, we must support the interests of the patient," Dr. Jones said. "Medicine is an occupation that strives to maintain trust. In the heart of every patient there must dwell the questions: Can I trust this doctor? Is he/she committed to excellence? Does he/she care about me?"

Dr. Jones noted that while change is a constant, "some things do not change: the medical profession's mission of service. The medical profession has served the interests of societies and patients since hundreds of years before Christ," he added. "We must never forget that we are here to serve."

The ACS chapters: *Where do we go from here?*

by Robert M. Quinlan, MD, FACS,
Worcester, MA

Based on the course of surgical leadership discussions over the past few years and the findings generated through the American College of Surgeons's (ACS's) strategic planning process, it appears that the ACS/chapter relationship is at a crossroads. Having attended the 2001 Chapter Leadership Conference, I have the sense that the ACS and its chapters have a less-than symbiotic relationship. Dr. Russell's column in the July 2001 *Bulletin* confirms this belief when he states, "I do not believe that the chapters can continue to function in their current manner," and "I believe the College must not only maintain but strengthen its chapters." So, where do we go from here?

The Massachusetts experience

Please allow me to share with you a little bit about the Massachusetts experience. The Massachusetts Chapter of the ACS was chartered nearly

50 years ago as an organization rich in surgical history and spawned from other collaborative societies, such as the prestigious Boston Surgical Society and the New England Surgical Society. Currently, more than 1,700 Fellows of the College (1,264 active FACS) are based in Massachusetts, yet the chapter has only 593 active members (47% of the market share). In fact, in the past 10 years, active chapter membership has decreased 27 percent, while senior (non-dues paying) membership has increased 45 percent.

This trend tells us not only that our membership population is aging, but that the members of our next generation of surgical leaders are not joiners—or, at least, they certainly aren't inclined to participate in the chapter. Membership attrition is now directly affecting the financial stability of the Massachusetts Chapter as total dues income (\$150 per Fellow) just covers our administrative management, four Council meetings per

year, and two semiannual newsletters. The surgical leaders throughout the Commonwealth are very much engaged, yet there remains a disconnect with our rank-and-file members. Respondents to membership surveys consistently ask the question, “What does the chapter do for me?”

Benefits of membership

The tenet of my presidential year was answering the question, “What are the benefits of chapter membership?” My research, statistics, and some good old-fashioned shoe leather (worn through my travels around the state) told me that there are some very real benefits of chapter membership! The problem is that those benefits are intrinsic and have not changed very much over our 50-year history. In fact, some traditionally perceived benefits are really of no value to our younger members.

So, what are the benefits? Following are some of the real, observable benefits of belonging to the Massachusetts Chapter and I suspect other ACS chapters, as well.

- *Camaraderie.* Surgeons like to get out of their operating rooms and interact with one another. We help facilitate collaboration through meetings of our council, the 35 members of which include our officers, our regional state representatives, ACS Governors, ACS Regents, other College representatives, and the chairs of various committees. This body meets quarterly. We also host an annual meeting in December, which traditionally attracts 150 members. We have also instituted a Town Meeting Program (discussed more completely later in this article), which allows the chapter leadership to hear firsthand the issues affecting practicing surgeons in their academic institutions or in their communities.

- *Mentoring.* Massachusetts has adopted and promoted the new Candidate and Associate Society of the ACS (CAS-ACS), and we recently appointed three representatives of the CAS-ACS to sit on our Council. In addition, we are attempting to deliver programs to address key concerns of young surgeons, including financial planning, insurance, applying for a position, negotiating contracts, and so on. This program is in its early stages and has become the pet project of our current President, Maureen Kavanah, MD, FACS. Additionally, for the past three years, we have offered

a very popular “Meet the Professors” breakfast as part of our annual meeting. These programs all have been aimed at mentoring the future surgical leaders within the Commonwealth, and it appears that while camaraderie is less important to our younger generation, young surgeons appreciate our mentoring efforts.

- *Education.* The Massachusetts Chapter has offered an annual meeting for 47 years. For 24 of those years, we have also offered a spring meeting. Frankly, with all of the educational opportunities available, especially through specialty and subspecialty organizations, it appears that rank-and-file chapter members are not attending scientific meetings as much for educational purposes but for the camaraderie and mentoring opportunities.

- *Farm system.* The ACS looks to the chapters to recommend/nominate the necessary future surgical leaders. The successful chapter leader universally enjoys the experience and is appreciative and enthusiastic about providing additional service to the ACS and the practice of surgery in the roles of Governors, Regents, and Officers. My baseball reference to “farm system” aside, chapters are instrumental in developing grassroots initiatives and future leaders of the College.

- *Socioeconomics.* The Massachusetts Chapter has long been committed to developing strategies to deal with socioeconomic, coding, and reimbursement issues. All of our member surveys have told us that a local voice on socioeconomic issues is highly important to the practicing surgeon. In addition, our chapter leadership has recognized the importance of these strategies in enhancing our practices as well as revitalizing the chapter.

Five or so years ago, the Massachusetts Chapter was financially flush, with nearly \$500,000 in reserves. The leadership of the organization realized that this surplus had to go back into a program as a member benefit. As the penetration of managed care increased, the leadership decided to develop legislative, political, and media strategies to combat the negative effects of the managed care industry. We collaborated with other political and health care leaders in the Commonwealth as part of an effort to write, manage, lobby, and ultimately pass a sweeping managed care reform package.

This omnibus bill addressed restrictions on

capitated systems, point-of-service options, physician referral systems, and ERISA. The Massachusetts Chapter accomplished the following: we attained representation on the governor's health care commissions; we encouraged the state legislature and the U.S. Congress to revisit ERISA issues; we helped bring focused attention to the emerging capitation system; and we drew the attention of leaders to the need for unlimited access to surgeons. This three-pronged approach to dealing with the state's executive branch, legislature, and the local media proved to be a successful formula. The Governor and legislature appointed a surgical representative to every major commission addressing the issue. We met with key legislative and gubernatorial administration representatives, we offered testimony to public hearings, we generated a letter-writing campaign, we met with the press, and we wrote opinion pieces for every major newspaper in the Commonwealth.

The end result was exciting. The legislature adopted an omnibus managed care bill that included fixes to the ERISA problems. The Governor issued an executive order prohibiting the state from dealing with insurers that offered capitated systems. The Massachusetts House and Senate each passed legislation restricting capitation and offering better access to specialists. In addition, we successfully raised public awareness about ERISA, capitation, and the importance of access to the physician of your choice. We also succeeded in raising the level of awareness of the practice of surgery and, in so doing, enhanced the profile of the Massachusetts Chapter. In the end, a multi-level dynamic was at work, which we found very interesting—in fact, enlightening.

First, the campaign was not easy, and it was not cheap. Our executive director coordinated our efforts with the assistance of hired public relations and legislative consultants. The cost of the campaign consultants was \$60,000 per year and depleted our assets from the time of our involvement through the signing of the bill. The momentum and profile for the chapter dimmed as our funding and capital faded. Second, we were very helpful in bringing many of the damaging effects of managed care to media forefront. But, did we bring about legislative reform? We did, partially, but not entirely. Advocacy and its success or failure are very hard to measure. Passage of the legislation

ultimately was the will of the general public. For all of the political maneuvering and legislative and media manipulation, the practice of managed care was reformed because the people demanded regulation of the industry. So, not only did our chapter learn a lesson about public advocacy, but we realized that organizational participation in advocacy comes with a price, and in order to be truly effective and successful, the public has to be on your side. In our profession, success must always be reflected through the care of our patients.

- *Town meetings.* As President of the Massachusetts Chapter, I was curious about the relationship between the ACS and its chapters, and I wanted to know why the organizational structure made the central operation so strong and left the chapters so vulnerable. Surveys only gave me partial answers, and many of them could have a deviation based upon what and how the questions were asked. I needed to be sure. So, we instituted a Town Meeting Program, which allowed me to travel to five regions of the state to meet directly with the membership in their respective departments and communities to get straight answers to the important questions. We focused on what we thought were the important issues—those that we felt might help us understand the differences in relationship between the Fellows and the ACS and the one between the Fellows and the chapter. Those questions and issues included:

- What is the perceived opinion regarding the current relationship between the ACS and the regional chapter?
- What is the ACS/chapter role in the overall practice of surgery?
- What are the most important services the ACS/chapter can provide?
- How active and what role would the membership like to see the ACS/chapter play in the socioeconomic and political agenda?

The answers varied, but the themes were consistent at all of the town meetings. The role of the ACS was more defined than that of the chapter. However, the question continued to dog the value of chapter membership: What does the Massachusetts Chapter do for me?

Health policy and education remain the two services that Fellows demand of both the ACS and the chapter. The members want both organizations to be more involved in all health policy and

political issues. The members want respect restored to the surgical profession. “Develop advanced public and media relations to accompany the political agenda portraying the surgeon as a champion for patient care,” the members said. They specifically suggested that the ACS weigh in on other health care issues, such as specialty-specific concerns, the nursing shortage, surgical errors, quality of life, surgical training, residents’ rights, and so forth. They want answers to the following questions: What is the ACS doing to ensure the maintenance of competency? What is the ACS role in recertification? How does the ACS view the different education and other needs of academic-based and community-based surgeons?

We traveled armed with Dr. Russell’s August 2000 *Bulletin* column outlining the benefits of Fellowship in the College. Our meetings showed that either the membership didn’t read the article or, more importantly, did read it but didn’t connect to the sentiments expressed. The rank-and-file members concerned with their grassroots issues feel disconnected from the chapter and the College. This disconnect drives the members’ disenfranchisement. The chapter certainly can’t stem this tide alone. The answers and approaches to resolving these questions for both the ACS and the chapter will not be satisfied by this article alone. But in the process of instituting these town meetings we realized that perhaps one benefit of both memberships is that the surgical leadership is willing to travel to your community and institution to hear your opinion.

Next steps

So, where do we go from here? The Massachusetts Chapter is entering into a period of strategic planning ourselves. I am going to ask our Strategic Planning Committee to consider some of the ideas that came out of the limited town meetings that we have held so far. (The program is ongoing and has been instituted as a formal Massachusetts Chapter endeavor.) At this point, my conclusions are as follows:

- The College should consider reorganizing using a bottom-up (grassroots) management approach as opposed to what is perceived as top-down management style. The ACS should consider setting its agenda based on information gathered from the chapters. This might ensure a philosophi-

cally unified ACS instead of one national organization and 67 independent chapters.

- If such a reorganization were implemented, might the ACS distribute one bill encompassing dues for both bodies? This way, dues income would support the actions of the national organization and would provide the chapters with a mechanism to increase their revenues.

- The College should consider defining chapter responsibilities, such as: recruiting, promoting, and processing Fellowship in the ACS; developing educational objectives and other issues for young surgeons; and stimulating advocacy for local socioeconomic issues.

- The ACS should revisit the importance of their Washington representation, the development of the socioeconomic agenda, and the creation of a political action committee. Local participation in these efforts will greatly enhance and support the ACS agenda.

- The College should financially support its agenda through local chapter efforts. The ACS should establish programs that make funding available to support the chapters. In turn, this backing will promote the practice of surgery and provide benefits to the membership of the ACS.

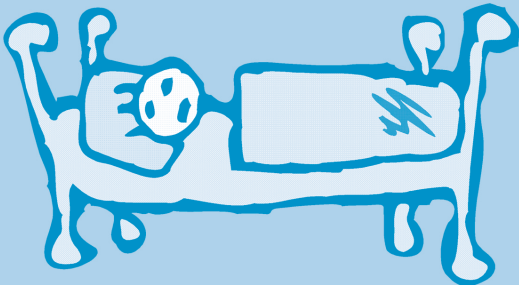
If the chapters truly are the lifeblood of the ACS, then our combined leadership must continue to strive for common ground—fostering patient care. The Massachusetts Chapter looks forward to working with the College on these continued efforts. □

Dr. Quinlan is a professor of surgery at the University of Massachusetts, a surgical oncologist at the UMASS Memorial Health Center, and the Immediate Past-President of the Massachusetts Chapter of the College.



Federal programs providing health insurance to children: A review

by Erin LaFlair,
Legislative Assistant,
Division of Advocacy and Health Policy



The federal government began its efforts to provide health insurance coverage to low-income individuals in 1965 with the creation of the Medicaid program. Unfortunately, decades later, millions of children were slipping through this safety net because they failed to meet Medicaid eligibility requirements. The good news is that recently implemented government programs now provide funds that enable more than 3 million children to obtain health care services through state-level initiatives. In addition, state and local governments have made it a priority to use these funds and the increased flexibility accorded by the federal government to reach out and improve access for more uninsured families.

Surgeons who care for children should be familiar with the two principal federal programs aimed at providing health care coverage to children—the State Children’s Health Insurance Program (SCHIP) and the Medicaid program. This article provides a brief overview of these programs, as well as information about pertinent legislative initiatives pending in Congress that would further expand health insurance coverage and improve care for the nation’s children.

Overview of the Medicaid program

Medicaid, created in 1965 as a cooperative venture funded jointly by the states and the federal government, provides medical assistance for certain low-income individuals and families, mostly women and children. Under this partnership, the federal government covers 50 to 83 percent of the Medicaid program costs in each state. In addition, the program operates under broad national guidelines, which allow states to establish regulations and standards that best suit the needs of their citizens. For example, states are able to determine their own payment methodologies, payment rates, deductibles, and co-payments.

Although states may choose to enroll recipients in fee-for-service or managed care plans, all state Medicaid programs must provide financial assistance for a core set of services. Standardized benefits include inpatient and outpatient care, hospital services, prenatal care and vaccinations for children, physician and rural health clinic services, lab and X-ray services, and pediatric and family nurse practitioner services.

Overview of SCHIP

SCHIP, created in 1997 under provisions in the Balanced Budget Act, provides federal funding to help states initiate and expand health insurance programs for low-income children whose families are currently ineligible for Medicaid. States may use this money to create a new program that meets the statute's health insurance coverage requirements, to expand eligibility for children under their Medicaid programs, or to support a combination of both. Although states are required to petition the federal government for these funds, the U.S. Department of Health and Human Services (HHS) routinely approves these requests.

While HHS has been generous about approving SCHIP programs, the amount states may receive from the federal government is limited: \$40 billion for the entire program over a 10-year period. Allotments are based on a formula that reflects each state's proportion of low-income uninsured and insured children, as well as a geographic adjustment factor.

Expanding SCHIP enrollment

At the end of 2000, more than 3.3 million children were enrolled in SCHIP, and this figure continues to increase as states make their eligibility requirements more consistent. For example, most states have created a single income eligibility threshold for all families with children under age 19. Now that all 50 states and the District of Columbia have implemented approved children's health insurance programs, state governments are considering new approaches to reach children who may be eligible for coverage but are not yet receiving it. In addition, states are working to ensure that children who currently are enrolled retain their coverage when their families' economic circumstances change. Further, the states' focus is being directed more toward enrolling targeted, hard-to-reach minority populations.

To give states more flexibility in their efforts to enroll children in SCHIP, the Benefits Improvement and Protection Act of 2000 (BIPA) was signed into law in December 2000. Under this law, health centers, elementary and secondary schools, and homeless shelters now may enroll children on a presumptive eligibility basis. Previously, SCHIP eligibility had to be proven before enrollment was possible.

In addition, when SCHIP was first enacted, states that did not spend their allotments were prohibited from using it in later years, and the federal government was barred from redistributing it to other states that had exhausted their funds. However, BIPA allows states to retain and use until fiscal year (FY) 2002 unspent SCHIP funds from FYs 1998 and 1999. This provision frees up a total of \$1.9 billion in unused funds. This money, originally intended to be divided among states that had spent their entire allotments, ultimately was divided among 41 states with 60 percent of the funds funneled to those states that had not spent their initial allotments.

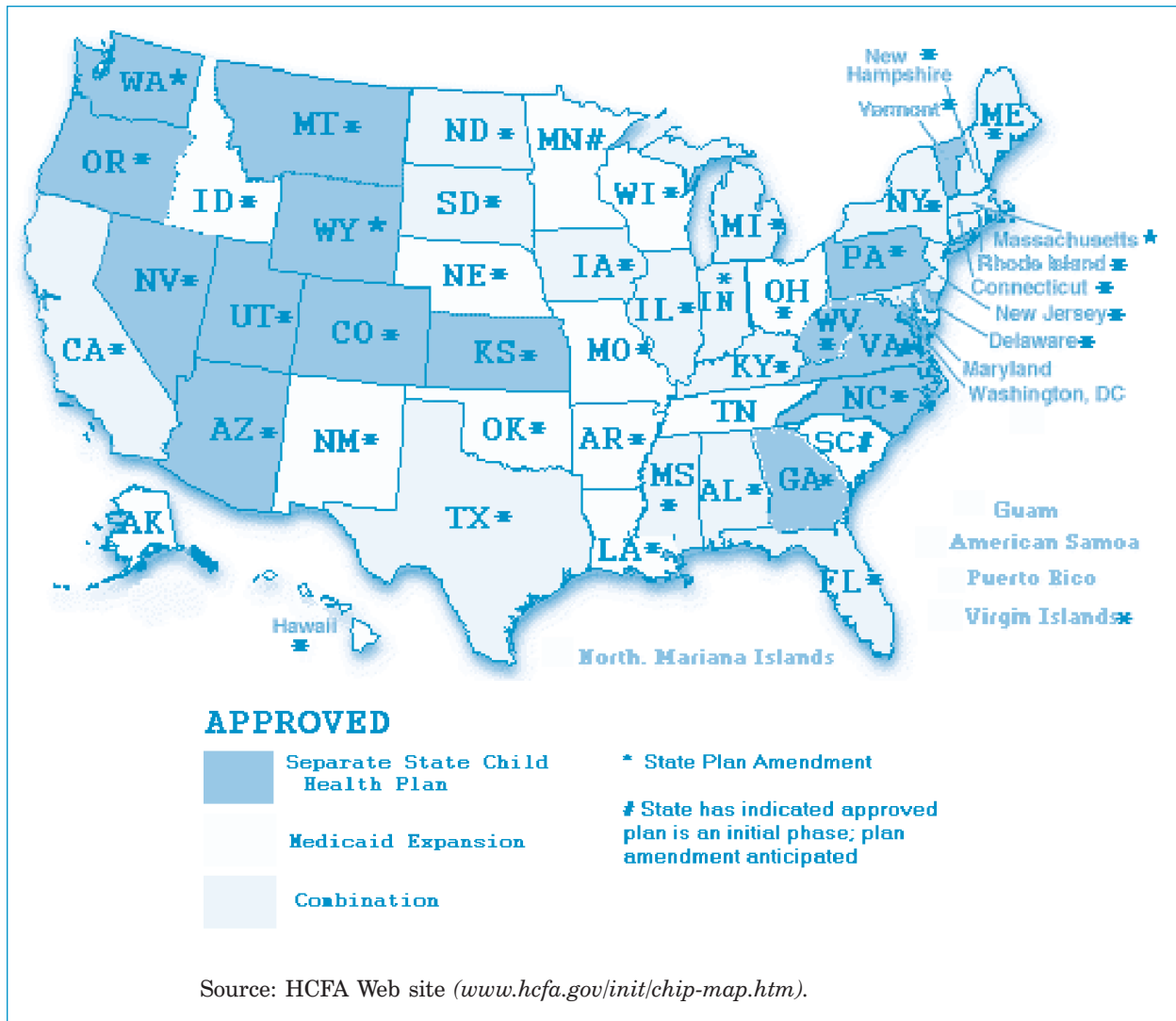
HHS has actively encouraged states that have retained their unused SCHIP funds to use the money to develop new enrollment approaches. The department has suggested that states spend 10 percent of the funding to expand efforts to locate eligible children and another 10 percent on appropriate outreach activities identified through these search programs. HHS also is encouraging federal health centers to help states increase their SCHIP enrollment. Federally funded health care centers serve a large number of low-income children, and states have been instructed to provide enrollment training to personnel in these centers.

Most recently, HHS's Centers for Medicare & Medicaid Services (CMS) published an interim final rule on SCHIP. Originally published in final format last January, just days before the Clinton Administration left office, the rule was put on hold by the Bush Administration until it could further review the regulation. In June, CMS published a new interim rule, which included changes and a request for public comment. One amendment is intended to help expand program enrollment by eliminating the requirement that parents or legal guardians provide the Social Security number for both themselves and their children when enrolling in the program. This modification, according to CMS, will allow states to more effectively enroll children on a presumptive basis.

Efforts to expand coverage

CMS and state health departments are finding it equally important that they increase the efficiency and accessibility of SCHIP and Medicaid by expanding the covered population. In June, an independent study conducted by the Common-

SCHIP plan activity



wealth Fund suggested to CMS that another 2 million children could potentially receive health insurance if states were to set the same eligibility requirements for SCHIP and Medicaid enrollment for parents as exist for children. The Commonwealth Fund reasoned that permitting parents to enroll in the programs would spur an increase in the number of children covered. States now are able to extend Medicaid eligibility to parents, and CMS has recently developed a demonstration project to cover parents under the SCHIP program.

In another attempt to reach out to low-income parents, CMS is requesting comments from states on whether to extend SCHIP coverage to pregnant women. While prenatal care is a basic covered service under Medicaid, CMS wants to give states the option of providing these services to pregnant women whose incomes disqualify them from coverage under that program.

Additionally, in August, CMS introduced a new Health Insurance Flexibility and Accountability (HIFA) demonstration initiative. This demonstra-

tion project was designed to address the coverage needs of individuals with incomes less than 200 percent of the federal poverty level, who generally are ineligible for Medicaid. The goal of this program is to give states the option of offering different benefits levels to people at various income levels in order to extend coverage to more uninsured people. To implement this program, a state must seek a waiver from HHS that allows it to amend its Medicaid and/or SCHIP laws and submit a proposal to expand coverage.

The challenge for states under the HIFA initiative is to take advantage of the increased flexibility these programs offer without spending more than their current allotment of federal funds. Participating states must continue to comply with Medicaid's rules, which mandate coverage for children under age six and pregnant women with incomes up to 133 percent of the federal poverty level. States may opt to extend Medicaid coverage to qualifying elderly and disabled populations, parents of SCHIP recipients, and individuals whose earnings total 200 percent of the federal poverty level. These optional populations should receive a benefit package that includes the same basic services as current SCHIP recipients.

Advocates for expanded coverage have expressed concern that some states will increase cost-sharing and limit benefits to achieve cost savings if these proposals are implemented. The National Governors Association, however, has said states are unlikely to impose these cost-cutting measures due to fears of a potential political backlash. States with waivers that had been approved as of press time for HIFA included Florida, Minnesota, New York, and Wisconsin.

Meanwhile, the Bush Administration has identified regulatory reform as a priority means of helping states to increase coverage for low-income children and their parents. HHS believes the slow federal process used to approve amendments and demonstration waivers has prevented many governors and state health departments from developing new approaches to expanding SCHIP and Medicaid coverage. With promises of a quick review process and less red tape, HHS reports that 910 new state amendments and waivers have been approved since January, resulting in expanded coverage eligibility for an additional 800,000 people.

Congress also has sought to broaden coverage

for uninsured families. Sens. Edward Kennedy (D-MA) and Olympia Snowe (R-ME) and Rep. John Dingell (D-MI) introduced a bill called the FamilyCare Act of 2001, S. 1244 and H.R. 2630, respectively. Among other provisions, this legislation would: (1) rename SCHIP the FamilyCare program; (2) extend optional FamilyCare coverage to parents of targeted low-income children; (3) provide automatic eligibility for coverage to children of a parent on FamilyCare assistance; (4) allow optional Medicaid and FamilyCare coverage for legal immigrants and children through age 20; (5) limit specified conflicts of interests under Medicaid and FamilyCare; and (6) increase FamilyCare allotments for FY 2002 through 2004. As an incentive, states also would receive increased funds for expanding coverage to parents. Lastly, the bill would allow additional organizations to determine whether children are presumptively eligible, and information on SCHIP and Medicaid would be included on the National School Lunch Program application. The legislation is awaiting further action in Congress. (See map, opposite page.)

Changes in Medicaid managed care

Along with the SCHIP final rule, the Clinton Administration published a final regulation pertaining to Medicaid managed care shortly before leaving office. This rule was written to provide Medicaid beneficiaries enrolled in managed care plans with the same protections that would be provided under pending patient protection bills. This regulation, like the one pertaining to SCHIP, was delayed for further review by the Bush Administration. In August, a new interim rule was published with the promise that the revised final regulations would take effect in early 2002. When it becomes effective, the rule will provide Medicaid beneficiaries with the following protections:

- Coverage for emergency department care whenever and wherever needed.
 - Access to a second opinion.
 - Protection for patient-provider communication, including a prohibition against gag clauses.
 - Assurances of network adequacy to meet the needs of expected enrollment in the service area.
 - Comprehensive plan information for beneficiaries.
 - Grievance and appeals systems.
- Adhering to its pledge to decrease regulation,

HHS also is looking for ways to increase states' flexibility to determine the best methods for providing these Medicaid managed care protections. This rule is viewed as a "floor," meaning those states that already have implemented patient protections that are stronger than those specified by HHS may continue to enforce them.

Other pediatric programs

Following September's terrorist attacks in New York, NY, and Washington, DC, HHS determined that some children may need proper treatment for traumatic stress. In October, HHS awarded \$10 million to the National Child Traumatic Stress Initiative. This program is intended to support improved treatment and services for childhood trauma, increase accessibility to community centers, and promote clinical research aimed at providing adequate care to children who experience psychological trauma.

A variety of grants will be awarded through HHS's Substance Abuse and Mental Health Services Administration. One type of grant is intended for health care facilities to establish treatment/services development centers that will be charged with identifying, improving, and developing effective treatments for traumatic childhood events, such as witnessing and experiencing violence, loss of family, traumatic injuries, medical procedures, natural disasters, war, and so forth. At press time, such grants had been awarded to Boston Medical Center in Boston, MA, the Early Trauma Treatment Network at the University of California, San Francisco, CA, Northshore University Hospital in Long Island, NY, Yale University in New Haven, CT, and the Allegheny-Singer Research Institute in Pittsburgh, PA.

To deal with other childhood conditions, Rep. Sue Kelly (R-NY) introduced H.R.792, the Treatment of Children's Deformities Act of 2001. This legislation, supported by the College, requires that group health plans and health insurance carriers cover outpatient and inpatient diagnosis and treatment of a minor child's congenital or developmental deformity, disease, or injury. All surgical treatment that in the opinion of the treating physician is medically necessary to create a normal appearance would be covered under the legislation. At press time, the bill enjoyed the bipartisan support

of 76 cosponsors, although no floor action had been scheduled.

Conclusion

Federal and state governments have been successful in their renewed efforts to reach out to uninsured children. Yet, policymakers realize much more must be done to meet the coverage needs of all children who are at or near the poverty level. According to the Administration, an eased regulatory burden and more flexibility for states in designing their enrollment practices and coverage policies will result in greater efficiency and allow the states to focus more of their attention on the specific needs of local communities. This open door to innovation, combined with financial support and continued analysis of the issues involved, holds promise for addressing the long-resistant problem of assuring that children have access to the health care services they need. □

The most recent crisis faced by physicians in their ongoing struggle with professional liability is the double-digit yearly increase in the cost of professional liability insurance, which is occurring at a time when physician income continues to steadily decline.

Roots of the problem

During the past 30 years, physicians have faced a number of crises related to the cost of professional liability coverage. The first crisis was sparked in 1975 when professional liability insurance company actuaries discovered that they had neglected to react to rising loss ratios in preceding years. Commercial insurance companies responded by either raising rates significantly or, as more often occurred, by dropping professional liability coverage entirely. This situation led to the decreased availability of professional liability insurance, and many physicians were unable to purchase professional liability insurance or were forced to pay an exorbitant price.

Physicians and state governments responded dramatically to this problem. With the stability of our health care system threatened, most states reacted by passing legislation aimed at containing the problem, and some states formed joint underwriting associations to establish an insurance market. Some states, including California, passed meaningful legislation (such as the Medical Injury Compensation Reform Act) that significantly eased the problem. Most other states approved less effective reforms that did little to protect physicians or the fragile market. Medical organizations and physicians' groups took steps toward creating their own insurance market by forming professional li-

ability insurance vehicles, such as physician mutuals, offshore captives, risk-retention groups, and insurance trusts. These efforts succeeded in creating a market for professional liability insurance but did little to improve the tort system.

In the early and mid-1980s, the professional liability insurance problem again reached crisis proportions. Driven by a significant increase in both the number of claims filed and the size of the settlements awarded by juries, professional liability premiums began rising yearly at double-digit rates. Some physicians faced rate increases of 50 per-

cent or more per year.

To respond to this crisis of affordability, state legislatures again took action but once more enacted reforms that proved to be too narrow in scope or, in many cases, were later found to be unconstitutional by the state judicial systems.

Temporary relief

For unexplained reasons, the rise in frequency of claims and severity of awards moderated during the late 1980s and early 1990s. During this period the claims inflation rate was

still increasing by approximately 4 to 5 percent annually but was deemed manageable in light of the exorbitant increases experienced in the early 1980s.

In the early 1990s, with physician mutual companies insuring some 60 percent of the physicians in the U.S., a fundamental shift occurred in the rating mechanisms used by professional liability insurance companies. The agencies responsible for rating professional liability insurance companies became concerned that physician mutuals, most of which limited their coverage to a single state, were more intrinsically risky because of their geographic concentration. As a result, these rating

DOUBLE-DIGIT PREMIUM HIKE: THE LATEST CRISIS IN PROFESSIONAL LIABILITY

BY

**BARRY M. MANUEL, MD, FACS,
BOSTON, MA**

organizations began advising physician mutual insurance companies to extend their penetration into other states in order to spread the risk and maintain their high ratings. This action resulted in many physician mutuals expanding into other states, using a technique known as “burning into a market.” Using this mechanism, expanding companies lower their premiums below actuarially sound rates so they can penetrate new markets. Local companies seeking to retain their market share were forced to match these artificially low rates, resulting in predatory price-cutting with insurance being sold at inadequate rates.

Return of the high rates

After several years of price-cutting, reserves and surpluses at many physician mutuals began to deteriorate, necessitating a return to adequate, actuarially sound pricing. This situation created a need for large rate increases, not only to cover the current actuarially defined rates but, in many cases, to help restore the financial integrity of the insurance company. Several insurance companies had so greatly discounted their pricing that they were forced into bankruptcy or receivership, causing potential harm to their physician insurers. PHICO was taken over in August by the Pennsylvania regulators; soon after Frontier Insurance Group was taken over by New York regulators; and in October The MIIX, Inc. (formally known as Medical Inter-Insurance Exchange of New Jersey) was placed under supervision by the New Jersey Insurance Commissioner. Other large commercial insurers also experienced difficulty and responded by withdrawing from troubled markets and raising their premiums significantly in others (not quite to the extent experienced in 1975). One of the largest commercial professional liability insurers has indicated that it intends to reduce its book of professional liability insurance by 50 percent.

Failure or delay in diagnosis

The other driving force behind the latest crisis in professional liability is the rapid rise in claims alleging failure or delay in diagnosis. Traditionally claims against physicians have fallen into two categories. Perioperative problems (surgery, anesthesia, and recovery room) have accounted for 30 to 40 percent of the claims against physicians

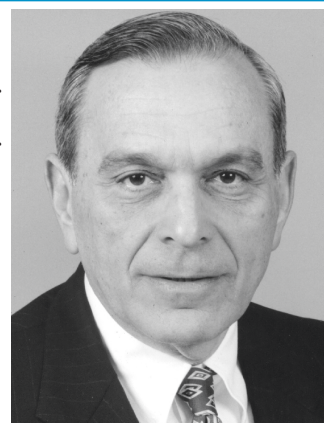
and indemnity paid to plaintiffs; birthing injuries were the other major category, accounting for some 25 to 30 percent of all claims and indemnity payments. Failed or delayed diagnosis was not on the radar screen 15 years ago, but now accounts for 50 percent of claims against and indemnity paid on behalf of physicians. Failure or delay in diagnosis of cancer is the leading cause of action, with breast cancer accounting for half of the cases, followed by colon and lung cancers. Delays as short as seven months have resulted in plaintiff verdicts, and there have been a number of plaintiff verdicts involving patients who were disease-free for five or more years after the alleged delay in diagnosis. Although all physicians have been affected by this trend, diagnostic radiologists and primary care physicians have been targeted most often. In addition, jury awards have skyrocketed beyond all reason. Jury Verdict Research of Horsham, PA, has reported that jury awards rose 79 percent from \$1.95 million in 1993 to \$3.49 million in 1999.

These circumstances have resulted in the latest crisis in professional liability. Some of the largest commercial insurers are raising their rates in many states by more than 30 percent. Even physician mutuals are being forced into double-digit rate increases averaging 15 percent nationally this year. Predictions are that these premium hikes will be necessary for the foreseeable future. Rate increases materially affect all physicians but are particularly devastating to individuals in high-risk specialties, such as obstetrics, neurosurgery, and orthopaedic surgery, where yearly premiums in some areas are approaching \$200,000 or more per

continued on page 51

Dr. Manual is associate dean and professor of surgery at the Boston University School of Medicine, Boston, MA.

He also is Chair of Regents' Committee on Patient Safety and Professional Liability.



Clinical Congress 2001:



Highlights

More than 12,300 surgeons, other physicians, exhibitors, guests, and convention personnel attended the 2001 Clinical Congress October 7-12 in New Orleans, LA. The 87th annual clinical meeting of the College offered its participants the usual opportunities to learn about the practice of surgery through lectures, panel discussions, postgraduate courses, motion picture sessions, and exhibits.

Nonetheless, some sessions set this year's Clinical Congress apart from its predecessors. In response to the September 11 attacks on the World Trade Center in New York City and the Pentagon in suburban Washington, DC, and growing threats of bioterrorism, the Clinical Congress featured a special session titled Unconventional Civilian Disasters: What the Surgeon Should Know. During this session, **David B. Hoyt, MD, FACS**, Chair of the College's Committee on Trauma, and **Donald E. Fry, MD, FACS**, Chair of the Board of Governors' Committee on Blood-Borne Infection and Environmental Risk, presented information about potential health problems stemming from the current international conflicts. Their comments were based on statements developed by their committees, which were published in the November *Bulletin*.

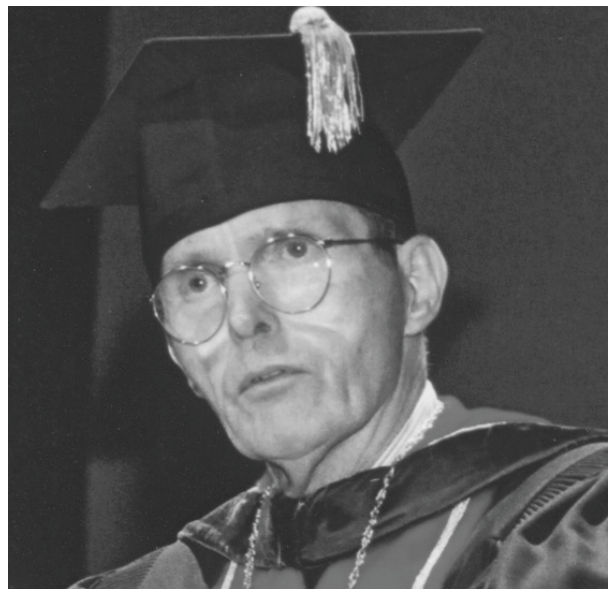
Other highlights of this year's Congress included the second presentation of both Programa Hispanico for Spanish-speaking surgeons and "A Day at the American College of Surgeons." The latter program made it possible for minority high school students from the New Orleans area to meet practicing surgeons and to experience the meeting.

Some other noteworthy moments were reported in the November *Bulletin*, including the presentation of the Distinguished Service Award to **David L. Nahrwold, MD, FACS**. The November issue also contained information about the three individuals who were awarded Honorary Fellowship in the College: **Pekka Häyry, MD, PhD**; **Minoru Hirano, MD, PhD**; and **Albrecht F.W. Encke, MD, FACS**.

Following are some other high points of the Clinical Congress.

Officers installed

R. Scott Jones, MD, FACS, a general surgeon from Charlottesville, VA, was installed as the 82nd President of the College during the Convocation



Dr. Jones giving his Presidential Address.



Dr. Carrico, President-Elect.

ceremonies. Dr. Jones is the S. Hurt Watts Professor and chair of surgery at the University of Virginia Health System in Charlottesville.



Dr. Hoyt (left) and Dr. Fry during their presentation regarding unconventional civilian disasters.

Dr. Jones centered his Presidential Address on organized medicine and how it has responded to political and economic pressures during the course of its evolution. Dr. Jones stressed the importance of understanding the history of these issues for young surgeons who are preparing to deal with modern-day challenges, such as the demand for improved quality of care and evidence-based medicine. A more detailed summary of Dr. Jones' address appears on pages 8-9 of this issue.

Further, **Kathryn D. Anderson, MD, FACS**, was installed as First Vice-President, and **Claude H. Organ, Jr., MD, FACS**, was appointed to the post of Second Vice-President. **John O. Gage, MD, FACS**, was appointed as Secretary.

Dr. Anderson is surgeon-in-chief and vice-president of surgery, department of surgery, Children's Hospital of Los Angeles, and professor of surgery, University of Southern California, Los Angeles, CA. She served as Secretary of the College from 1992 to 2001 and has been a member of the Advisory Councils for Surgical Specialties.

Dr. Organ is chair of the surgery residency program and professor in the department of surgery at the University of California, Davis-East Bay. He has been a member of the ACS Commission on Cancer and the International Relations Commit-

tee. Dr. Organ also is the 1999 recipient of the Distinguished Service Award.

A general surgeon in Pensacola, FL, Dr. Gage has been Chair of the College's General Surgery Coding and Reimbursement Committee since January 2001. He served on the Board of Governors from 1988 to 1994 and chaired its Committee on Socioeconomic Issues from 1997 to 2000. He received the College's Distinguished Service Award in 1995.

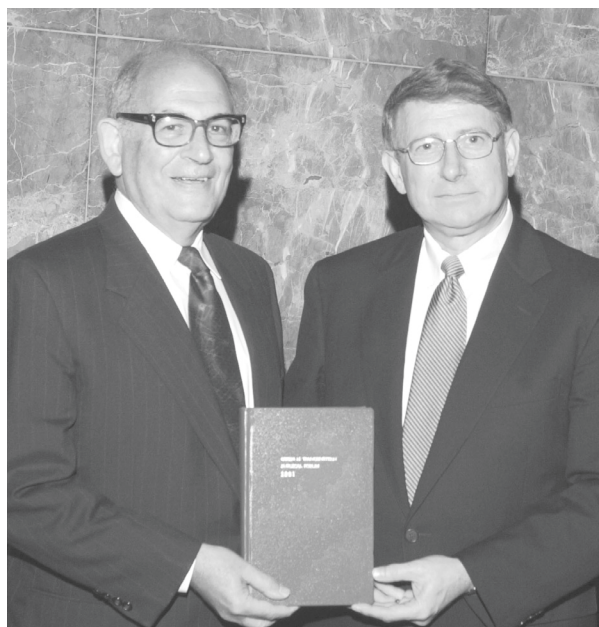
New officials

C. James Carrico, MD, FACS, of Dallas, TX, was named President-Elect during the Annual Meeting of Fellows and Initiates. Dr. Carrico is the Doris and Bryan Wildenthal Distinguished Chair in Medical Science and professor, department of surgery, at the University of Texas Southwestern Medical Center at Dallas.

A Fellow of the College since 1971, Dr. Carrico has served in a number of leadership roles within the organization. He served as the Chair of the Board of Regents from 1999 to 2001 and was a Regent since 1992. He also is currently a member of the Committee on Continuing Education; he served as that committee's Vice-Chair from 1984 to 1986 and on its SESAP IV and V Committees from 1980



During the annual meeting, Dr. Nahrwold (left) was presented with the 2001 Distinguished Service Award by Dr. Bender.



Dr. Simmons (right) received a copy of the *Owen H. Wangenstein Surgical Forum, Volume LII*, which was dedicated to Dr. Simmons, from Dr. Mentzer.

to 1982 and from 1982 to 1984, respectively. Dr. Carrico served on the Board of Governors from 1984 to 1990 and as its Chair from 1989 to 1990. In addition, he was a member of the Program Committee in 1995 and of the Pre- and Postoperative Care Committee from 1975 to 1983 and had a seat on the Executive Committee of the latter body from 1978 to 1981.

A specialist in burn, trauma, and critical care, Dr. Carrico was on the Committee on Trauma from 1982 to 1992; he was Vice-Chair of its Executive Committee from 1986 to 1989, Chair of the Washington State Committee from 1979 to 1982, and Chair of Region X from 1982 to 1990.

Dr. Carrico has been very active at the chapter level as well. He served as President of the Washington State Chapter from 1989 to 1990 and as President of the North Texas Chapter from 1996 to 1997.

Dr. Carrico earned his medical degree in 1961 from the University of Texas Southwestern Medical School at Dallas, where he subsequently per-

formed his research fellowship under the direction of G. Tom Shires, MD, FACS. He completed his internship and residency at Parkland Memorial Hospital in Dallas. After finishing his residency, Dr. Carrico served in the U.S. Navy and established the shock unit at San Diego Naval Hospital.

From 1969 to 1972, Dr. Carrico was an assistant professor of surgery at the University of Texas Southwestern Medical School; he served as associate professor of surgery at that institution from 1972 to 1974. Dr. Carrico then ventured to the northwest to work at the University of Washington School of Medicine in Seattle. While there, he served as associate professor of surgery from 1974 to 1976, professor of surgery from 1976 to 1990, and chairman of the department of surgery from 1983 to 1990. In 1990, Dr. Carrico returned to his roots to assume the role of professor and chair, department of surgery, at the University of Texas Southwestern Medical Center.

Dr. Carrico is a member of numerous medical and surgical organizations, including the Ameri-

can Association of Surgery of Trauma, of which he was president from 1992 to 1993. Dr. Carrico also holds membership in the American Surgical Association, American Trauma Society, scientific research society of Sigma Xi, Surgical Infection Society, Society of University Surgeons, and Société Internationale de Chirurgie.

A prolific author, Dr. Carrico currently serves on the editorial boards of the *Journal of the American College of Surgeons*, the *Annals of Surgery*, and the *World Journal of Surgery*.

In addition, Dr. Carrico serves on the Injury Research Grant Review Committee of the Centers for Disease Control and Prevention and the American Board of Surgery (ABS). He was president of the ABS from 1992 to 1993.

In other actions taken during the Convocation, the Fellows named **Richard R. Sabo, MD, FACS**, Bozeman, MT, First Vice-President-Elect, and **Amilu S. Rothhammer, MD, FACS**, Colorado Springs, CO, as Second Vice-President-Elect.

Dr. Sabo is a general surgeon in private practice and is a staff surgeon at Bozeman Deaconess Hospital. He was a Regent from 1991 to 2000 and Vice-Chair of the Board of Regents from 1999 to 2000. Dr. Sabo has been active on many ACS committees, including the Informatics, Central Judiciary, Communications, Organization, and Nominating Committees.

Dr. Rothhammer also is a general surgeon in private practice. She is on staff at Penrose Hospital in Colorado Springs. Dr. Rothhammer represents the College on the national Practicing Physicians Advisory Council and in the American Medical Association's House of Delegates. She is a member of the College's Development Committee and served as Secretary and Chair of the Board of Governors in 1996 to 1998 and 1998 to 1999, respectively.

Board of Regents

In other College actions during the Clinical Congress, **Edward R. Laws, Jr., MD, FACS**, was elected Chair of the Board of Regents. Dr. Laws is a professor of neurosurgery and medicine at the University of Virginia Health Sciences Center in Charlottesville, VA. He has been a Regent since 1994 and has served in various capacities on the Advisory Council for Neurological Surgery since 1991. Additionally, Dr. Laws has: chaired the Ad-



Dr. Thompson (left) presented the Distinguished Philanthropist Award to Dr. Satitpunwaycha.



The 2001 National Safety Council's Surgeons Award for Service to Safety was presented to Dr. Carrico (center) by Dr. Hoyt (left) and Dr. Maier.

visory Councils for Surgical Specialties and the Nominating Committee of the Fellows; served on the Central Judiciary, Medical Motion Pictures, and Fellowship Liaison Committees; and been a



Past recipients of the Distinguished Service Award gathered for their annual luncheon. Front row, left to right: John O. Gage, Josef E. Fischer, James C. Thompson, Seymour I. Schwartz, Harris B. Shumacker, Jr., and S. Stuart Mally. Back row: Vallee L. Willman, Claude H. Organ, Jr., Frank Padberg, Murray F. Brennan, C. Barber Mueller, and C. Thomas Thompson.

member of the Board of Governors.

Jonathan L. Meakins, MD, FACS, continues to serve as the Vice-Chair of the Board of Regents. Dr. Meakins is the E.W. Archibald Professor of Surgery and chair, McGill University, and is chief of surgical services at McGill University Health Centre in Montreal, PQ. He has been a Regent since 1993.

In addition, the ACS Board of Governors elected two new Regents—**Barbara L. Bass, MD, FACS**, and **A. Brent Eastman, MD, FACS**.

Dr. Bass is professor of surgery and vice-chair, academic affairs and research, University of Maryland School of Medicine, Baltimore, MD. She is the Immediate Past-Chair of the Board of Governors (B/G), serving in that function from 1999 to 2001, and was a member of the B/G Executive Committee since 1998. She also served as Chair of the Gov-

ernors' Committee on Surgical Practice in Hospitals from 1997 to 1998 and as a member of the ACS Communications, Organization, and Program Committees. She also is a member of the ACS Committee on Women's Issues. Dr. Bass has been a Fellow of the College since 1989 and will serve an initial three-year term as a Regent.

Dr. Eastman is N. Paul Whittier Chair of Trauma and an associate clinical professor of surgery at the University of California, San Diego. He has played an active role on the Committee on Trauma since 1984, serving as its Chair from 1989 to 1994. He has been an instructor for the Advanced Trauma Life Support® certification course since 1992. Dr. Eastman also is the former Vice-Chair of the Program Committee. He has been a Fellow since 1976 and will serve an initial three-year term as Regent.



The Past-Presidents of the College met for their annual luncheon. Left to right, front row: George R. Dunlop, James C. Thompson, Frank C. Spencer, W. Gerald Austen, C. Rollins Hanlon, and Henry T. Bahnson. Back row: Seymour I. Schwartz, David G. Murray, LaSalle D. Leffall, Jr., Lloyd D. MacLean, G. Tom Shires, and Thomas R. Russell, Executive Director.

The following surgeons were reelected to additional three-year terms as Regents: **William H. Coles, MD, FACS; Richard J. Finley, MD, FACS; Jack W. McAninch, MD, FACS; and Maurice J. Webb, MD, FACS.**

Board of Governors

With regard to the Board of Governors, **J. Patrick O'Leary, MD, FACS**, was elected to a one-year term as Chair of its Executive Committee. Dr. O'Leary replaces Dr. Bass in that position. **Sylvia D. Campbell, MD, FACS**, was elected to a one-year term as Vice-Chair of the Executive Committee and **Timothy C. Fabian, MD, FACS**, to a one-year term as Secretary.

The following individuals also were elected to the Board of Governors' Executive Committee: **Julie A. Freischlag, MD, FACS; Steven W.**

Guyton, MD, FACS; Rene Lafreniere, MD, FACS; and Courtney M. Townsend, Jr., MD, FACS.

Awards and honors

In addition to the presentation of Honorary Fellowships and the Distinguished Service Award, other distinctions accorded during the Clinical Congress included the dedication of the 51st volume of the *Owen H. Wangensteen Surgical Forum* to **Richard L. Simmons, MD, FACS**. The Committee for the Forum on Fundamental Surgical Problems dedicates the symposium each year to a preeminent surgical scientist who has made exceptional contributions to research and who is a role model for aspiring academic surgeons. **Robert L. Mentzer, Jr., MD, FACS**, Chair of the committee, presented the award.



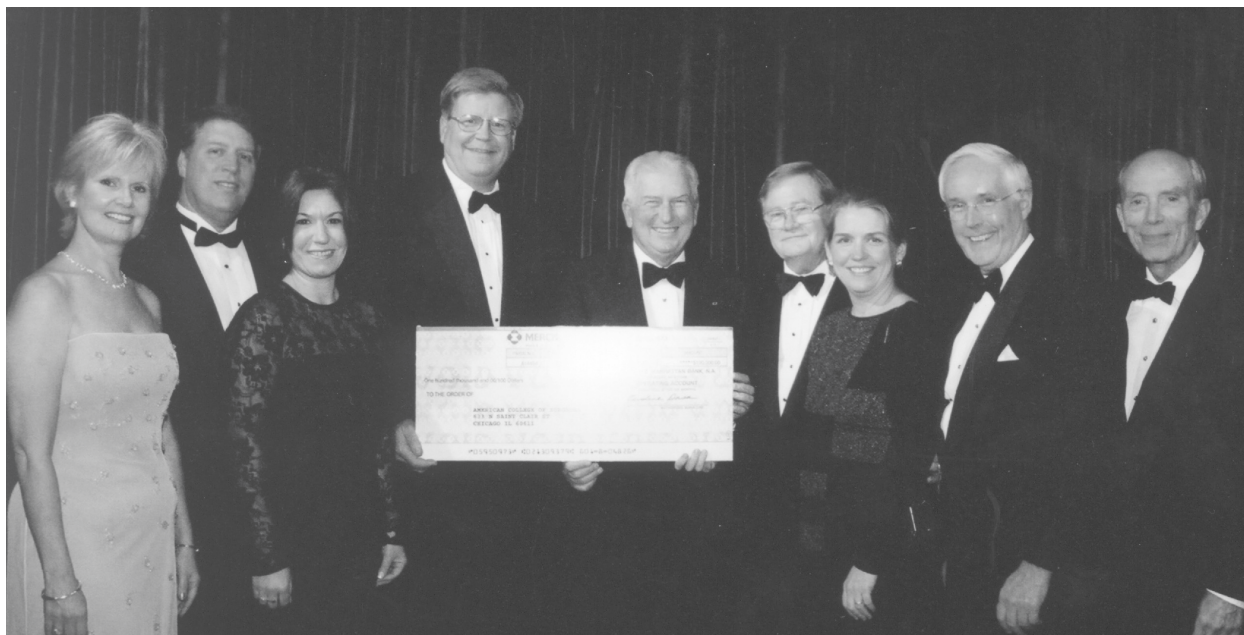
The International Guest Scholars for 2001 and International Relations Committee members met during the Congress. Left to right, front row: Dr. Lopez, Chair of the Selection Subcommittee; Dr. Sinagra; Dr. Rodriguez; Dr. Ezeome; and Dr. Kelly, Chair, International Relations Committee. Back row, left to right: Dr. Meneu-Diaz; Dr. Kuzu; and Dr. Corrales V.

Additionally, each year the Fellows Leadership Society (FLS) presents the Distinguished Philanthropist Award in recognition of extraordinary philanthropic support of the College. This year's award was presented to **Pon Satitpunwaycha, MD, FACS**, by **James C. Thompson, MD, FACS**, Chair of the FLS. Dr. Satitpunwaycha's generous support of the ACS Development Program has contributed significantly to the research and education programs of the College, helping to ensure progress in the science and art of surgery and ultimately benefitting surgical patients.

The 2001 National Safety Council's Surgeons Award for Service to Safety was presented to **Dr.**

Carrico, who is internationally recognized as an eminent surgical scientist and humanitarian dedicated to the care of injured patients. He has focused much of his professional career on illuminating the issues of injury prevention and safety. Presenting the award on behalf of the National Safety Council were **Dr. Hoyt** and **Ronald V. Maier, MD, FACS**, president of the American Association for the Surgery of Trauma.

Lastly, the International Relations Committee, chaired by **Keith A. Kelly, MD, FACS**, hosted a luncheon to honor the 2001 International Guest Scholars. Physicians receiving the distinction this year are as follows: **Juan**



Representatives of Merck & Co., Inc., U.S. Human Health, presented a check in the amount of \$100,000 in the form of an unrestricted educational grant to support the work of the College. This payment is the first of three scheduled unrestricted educational grants totaling \$300,000 to be made to the College over the next three years. Left to right: Merck representatives Linda T. Raichle, PhD; Richard Murray, MD; Rose Arnone; and Michael W. Skoien, RPh, MBA; and ACS Officers Harvey W. Bender, Jr., President; James C. Carrico, Chair, Board of Regents; Barbara Bass, Chair, Board of Governors; Thomas R. Russell, Executive Director; and Robert E. Berry, Chair, Development Committee.

Carlos Meneu-Diaz, Spain; **Emmanuel Rapuluchuk Ezeome**, Nigeria; **M. Virginia Rodriguez Funes**, El Salvador; **Mehmet Ayhan Kuzu**, Turkey; **Diego Luis Sinagra**, Argentina; and **Noel Ernesto Corrales V.**, Guatemala. The International Relations Committee's Selection Subcommittee is chaired by **Marvin Jose Lopez, MD, FACS**.

2001 Oweida scholar

William H. McGeehin, MD, FACS, Torrington, CT, received the 2001 Nizar N. Oweida, MD, FACS, Scholarship of the American College of Surgeons.

The Oweida Scholarship was established in 1998 in memory of Dr. Oweida, a general surgeon from a small town in western Pennsylv-

nia. The award of approximately \$5,000 is given to support travel and subsistence at the annual Clinical Congress, including post-graduate course fees. The purpose of the Oweida Scholarship is to help young general surgeons practicing in rural communities attend the Clinical Congress and benefit from the educational experiences it provides.

The Oweida Scholarship is awarded each year on a regional rotation basis by a subcommittee of the Board of Regents. □



Dr. McGeehin

Report of the Chair of the Board of Regents

*by C. James Carrico, MD, FACS,
Dallas, TX*

This has been a busy and productive year for the College. Under the leadership of Thomas R. Russell, MD, FACS, Executive Director, we have successfully completed a strategic planning process, the results of which can be found in the September 2001 issue of the *Bulletin*. I would encourage each of you to take the time to read it, if you have not already done so. As Dr. Russell points out in his "From my perspective" column in the September issue, this is not intended to be a static document, but a starting place to help the College move into the 21st Century.

One thrust of this plan is to focus on four divisions, which represent the primary services provided by the American College of Surgeons. These are: (1) education, (2) research and optimal patient care, (3) advocacy and health policy, and (4) member services. This report serves as a brief update on the status of each of these programs. Because this is my ninth and final year on the Board of Regents, I have taken the liberty of looking back to see what progress we have made in the last decade.

Education

Education has been a major thrust of the College since its inception. Major changes in our educational program began in the early 1990s with the establishment of the Committee on Emerging Surgical Technology and Education in response to the evolution of laparoscopic cholecystectomy and other minimal access procedures. Under the leadership of that committee and with extensive staff support, the College has made major progress in establishing a leadership role in recognizing and evaluating new technology.

The rapid evolution of new technology presented the College with the opportunity and responsibility to develop a series of hands-on courses specifically designed to educate surgeons

who had completed their "training" in the use and application of new techniques, such as ultrasound image-guided breast biopsies, and so on. These courses offer verification in the skills presented, and we anticipate that the breadth of this verification will expand. In addition, the College has now started a joint sponsorship program so that ACS courses may be offered by associated regional and surgical specialty organizations in order to make this type of education more broadly available.

Research and optimal care

With respect to research and optimal patient care, the College has provided research support and encouragement to the Fellows and residents, including the Clowes Research Career Development Award. Additional major advances in the last several years have been the direct involvement of the College itself in a number of primary clinical research projects, which include two hernia studies—one comparing laparoscopic with open hernia repair, and the other evaluating the role of watchful waiting in symptomatic hernias.

The studies being conducted by the American College of Surgeons Oncology Group (ACOSOG) under the leadership of Samuel A. Wells, Jr., MD, FACS, continue to accrue patients. ACOSOG is the only truly surgical oncology group receiving funding from the National Institutes of Health.

Recently, the College received support for three new projects. The largest is in conjunction with the Veterans Administration and will attempt to apply the National Surgical Quality Assurance Program methodology to private institutions. This program should help put the control of quality back into the hands of surgeons and keep it out of the hands of bureaucrats.

Additionally, Ajit Sachdeva, MD, FACS, the

new Director of the Division of Education, has just been notified that a major program exploring new ways to educate surgeons will be funded by the Agency for Healthcare Research and Quality. While some of our programs (for instance, the hands-on courses) provide immediate impact, some of these research programs will be extremely important to surgeons over a long period of time.

Advocacy and health policy

The College's Washington Office was established in 1979, and we purchased a building to house our federal affairs staff in 1988. Over the years, the Washington Office has grown progressively in terms of both size and effectiveness. Our efforts have successfully slowed the erosion of surgical income and, more recently, led to the establishment of significant new general surgery CPT codes. Dr. Russell addresses these new payment codes and related developments in his column on page 3. Over the next year, there will be major new efforts to modify health policy both through public education about the importance of Fellowship in the College and the quality of care that can be obtained through surgical specialty services.

Member services

The member services area has been streamlined and will be increasingly responsive to member needs. New programs are being added, and, as I think one can see, all of the major divisions really focus on services to members. The College has added the Candidates and Associate Fellows to the pool of formal members of the College and is considering the possibility of extending membership to other health care professionals.

Other business

Last but not least, at its meeting this past October, the Board of Regents approved the establishment of a 501(c)6 organization. This new organization will not only give us more freedom in terms of legislative activity, but will allow us to have increased flexibility in verification and credentialing activities, provide information to the Fellowship about outcomes, offer management services for other surgical organizations

(including the chapters), broaden our advocacy efforts, undertake revenue-producing activities, and increase our opportunities to participate in competency programs in conjunction with other appropriate organizations.

Closing thoughts

This ends my nine years of service on the Board of Regents. I am honored to have served and hope this review gives you some idea of the progress we have made over the last several years. □

Dr. Carrico is Doris and Bryan Wildenthal Distinguished Chair in Medical Science and professor, department of surgery, University of Texas Southwestern Medical Center, Dallas, TX.



Report of the Chair of the Board of Governors

*by Barbara L. Bass, MD, FACS,
Baltimore, MD*

It is my distinct honor to report on the activities of the Board of Governors. I can assure you that the Governors—the representatives of our Fellows—care deeply about the principles upon which this College was founded. The Fellows look to the College to support their efforts to provide the highest quality of care to their surgical patients. They also anticipate that the College will support them in their efforts to preserve and create health care systems in which their services are rendered in an effective, professional manner with due recognition and respect for the services they provide to their patients and communities.

Responding to terrorism

During the course of this Clinical Congress, the Governors' focus was drawn to the threat to our nation from the evil forces of international terrorism. One month after the attacks in New York, NY, and Washington, DC, the Governors expressed a clear commitment to being leaders in preparing our nation to protect and care for our citizens who are exposed to these threats. We committed to educating ourselves and the broader surgical, medical, and public communities about potential threats. The Governors urged the College to participate in crafting an immediate response plan.

As a first step, during the course of this meeting, the Governors' Committee on Blood-Borne Pathogens and Environmental Risk prepared a document on the unconventional and, to many, unfamiliar threats associated with acts of civilian terrorism. We request that this document be distributed to our Fellows rapidly and effectively. In conjunction with the Committee on Trauma, the Board of Governors calls upon the College to provide tangible leadership in helping to establish a network of preparedness in conjunction with civil and military authorities. This preparedness plan should include not only Fellows of the College but also should incorporate the talents of the mem-

bers of other surgical organizations in our country. I can assure you that the Board of Governors is unified in supporting the development and implementation of such a preparedness plan and considers this the most important mission for our College in these uncertain times.

Charges to College

In the summer of each year—this year, prior to the events of September 11—the Governors send reports to the Chair of the Board of Governors detailing their concerns as surgeons. This year, 233 Governors submitted annual reports. These included 137 Governors-at-Large in the U.S. and Canada, 28 Governors in other countries, and 68 Governors representing surgical societies.

The Governors noted with gratitude the outstanding educational programs the College has continued to provide. For special commendation, they pointed to the hands-on courses in new techniques and technology, which allow practicing surgeons to add new procedures and techniques to their surgical armamentarium. They requested that the steps to allow verification of training to support credentialing, in conjunction with surgical boards, move forward.

The Governors applauded the College's commitment to defining best practices through evidence-based analyses. They charged the College with utilizing these data to improve the care of the surgical patient and to support the surgeon in practice who, over the course of a career, continually strives to improve his or her own understanding of the science of surgery.

The Governors continued to voice serious concerns regarding the impact of managed care and government agencies on the profession of surgery. The Governors lauded the success achieved by the advocacy efforts of Fellows on the College's General Surgery Coding and Reimbursement Committee to improve payment for some surgical procedures but acknowledged that continued diligence

will be required to sustain even these modest gains. An even greater concern was voiced regarding the onerous burden of complex coding and billing systems, which require ever greater efforts by practice staff, which, in turn, result in higher costs with the final result being decreased payment for surgical services. The strains that managed care contracts have introduced to the surgeon-patient relationship was decried. The Governors urged the College leadership to continue to enhance its advocacy efforts on behalf of the Fellows in these important areas.

As the College moves toward establishing a new organizational structure to enhance its functions, the Governors requested the leadership to continue to pursue options that will strengthen its voice in legislative bodies at both the state and national level. A political action committee, as proposed by the Governors one year ago, may prove to be an effective tool to this end. The Governors also proposed that the College consider development of a broader legislative action program to enlist grassroots support from surgeons and their patients.

With urgency, the Governors in many states reported skyrocketing malpractice premiums. They asked the College to consider new strategies, with targeted local efforts, coalition building with other organizations, and an awareness campaign directed toward our patients to make some progress on this new exacerbation of an old problem.

Additionally, the Governors noted with concern the declining interest in surgical residency training. While the Governors acknowledged that the causes of this decline are many and complex, they recommended that the College seize this opportunity to educate the public and our students about the rare privilege of being a surgeon, highlighting the sophisticated talents, knowledge, and commitment a surgeon brings to his or her care of the surgical patient.

Conclusion

The Governors remained firm in their resolve to provide the best possible surgical care for their patients. They applauded the College for its longstanding role as the guardian of this mission. They requested that the ACS continue to seek out new avenues to augment the Fellows' effectiveness in this mission and they urged the College's lead-

ership to develop new tools and strategies to effect this mission. The Fellows will surely support and embrace these new and sustained efforts.

I am most grateful to have had this opportunity to serve as Chair of the Board of Governors. I thank all of the Governors for their diligent work on behalf of the College. 

Dr. Bass is professor of surgery and vice-chair, academic affairs and research, University of Maryland School of Medicine, and director, Surgical Clinical Care Center of the VA Maryland Health Care system, Baltimore, MD. She is also a Regent of the College.



*R*eport of the *Executive Director*

by Thomas R. Russell, MD, FACS,
Chicago, IL

As C. James Carrico, MD, FACS, reports on page 30, and as announced in the September 2001 *Bulletin*, the College completed its strategic planning process this year. Perhaps the most significant outcome of that process is the development of the four central divisions within the organization, each of which will have specific strategic initiatives that will be used as a yardstick to measure progress in these various areas of activity. The four core divisions focus on education, advocacy and health policy, research and optimal care, and member services.

This year, we also completed an extensive internal review of our structure and performance tools for the staff. This review was conducted by an outside consulting group. The findings were indicative of a dedicated and hard-working staff functioning in an appropriate work environment.

Divisions get to work

With the blueprint now set, our work really begins. In each of the four divisions, new and innovative activities must be pursued.

In terms of education, we clearly need to look very seriously at the way our products are delivered and at the likely future needs of surgeons in all specialties. As all of you know, there is a movement afoot focused on the maintenance of lifelong learning and competency. How it will be measured and met in the future remains to be seen. We are actively working with a number of organizations, such as the American Board of Medical Specialties, the Council of Medical Specialty Societies, and the various surgical boards, to study and eventually produce educational material to meet these needs. There also is an unmet need for patient education, the satisfaction of which I believe should be a high priority.

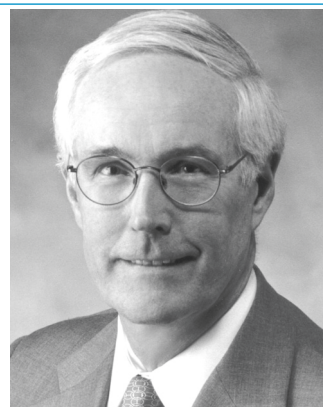
With regard to advocacy and health policy, we have developed and will continue to form strong coalitions with other surgical organizations. We currently are working closely with all the surgi-

cal societies and other physician organizations, such as the American Medical Association, to advance a legislative agenda that stresses those issues of most importance to surgeons. At the same time, we are acutely aware of the regulatory burdens that all of us practice under, and we will need to address this problem in a timely and proactive fashion. To that end, I believe the Health Policy Steering Committee, composed of a broad constituency of surgeons from all disciplines, will do much to respond in a timely fashion to activities in Washington and at the state level.

The new Division of Research and Optimal Patient Care and the Office of Evidence-Based Surgery will be critically important in the future with regard to evaluating data. The division also will assist us in determining best practices and the potential for clinical trials even beyond what we are currently doing through the American College of Surgeons Oncology Group. This office and division will be staffed with biostatisticians and will have the ability to write and obtain grants from various federal and non-federal agencies. We have already been awarded three grants from the Agency for Healthcare Research and Quality, which we will use to examine surgical outcomes and the work-

continued on page 53

Dr. Russell is
Executive Director of
the American College
of Surgeons.



ACS Officers and Regents

Officers/Officers-Elect



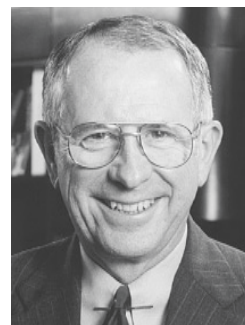
R. Scott Jones
President
General surgery
S. Hurt Watts Professor and
chair, department of surgery,
University of Virginia Health
System
Charlottesville, VA

Kathryn D. Anderson
First Vice-President
Pediatric surgery
Surgeon-in-chief and
vice-president of surgery,
Children's Hospital of
Los Angeles,
professor of surgery,
University of Southern
California
Los Angeles, CA



Claude H. Organ, Jr.
Second Vice-President
General surgery
Chair, surgery residency
program, professor, depart-
ment of surgery, University
of California, Davis-East Bay
Oakland, CA

John L. Cameron
Treasurer
General surgery
Professor and chair,
department of surgery,
The Johns Hopkins
University School of Medicine
Baltimore, MD



C. James Carrico
President-Elect
Trauma and critical care
Doris and Bryan Wildenthal
Distinguished Chair in
Medical Science and professor,
department of surgery,
University of Texas
Southwestern Medical
Center
Dallas, TX

Richard R. Sabo
**First Vice-President-
Elect**
General surgery
Private practice and
staff surgeon,
Bozeman Deaconess
Hospital,
Bozeman, MT



Amilu S. Rothhammer
**Second Vice-President-
Elect**
General surgery
Private practice,
Colorado Springs, CO

John O. Gage
Secretary
General surgery
Private practice,
Pensacola, FL



Board of Regents



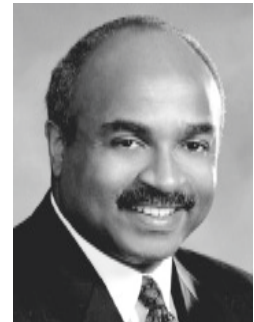
Edward R. Laws, Jr.
Chair
Neurosurgery
Professor of neurosurgery and medicine,
University of Virginia
Health Sciences Center
Charlottesville, VA

Jonathan L. Meakins
Vice-Chair
General surgery
E. W. Archibald Professor
of Surgery,
chair, McGill University,
chief, surgical services,
McGill University Health
Centre
Montreal, PQ



Barbara L. Bass
General surgery
Professor of surgery and
vice-chair, academic affairs
and research,
University of Maryland
School of Medicine
Baltimore, MD

L. D. Britt
General surgery
Brickhouse Professor and
chair, department of surgery,
Eastern Virginia Medical
School
Norfolk, VA



William H. Coles
Ophthalmic surgery
Professor emeritus,
State University of New York
New Orleans, LA

Paul E. Collicott
Vascular surgery
Private practice,
Lincoln, NE



Board of Regents (continued)



Edward M. Copeland III

General surgery

Edward R. Woodard
Professor and chairman,
department of surgery,
University of Florida College
of Medicine
Gainesville, FL

A. Brent Eastman

General surgery

N. Paul Whittier Chair of
Trauma and associate clinical
professor of surgery,
University of California,
San Diego,
San Diego, CA



Richard J. Finley

General surgery

C. N. Woodward Chair in
Surgery; professor and head,
division of thoracic surgery,
University of British Colum-
bia Faculty of Medicine
Vancouver, BC

Josef E. Fischer

General surgery

Professor of surgery
designate, Harvard
Medical School, and
chairman of
surgery designate,
Beth Israel Deaconess
Medical Center
Boston, MA



Alden H. Harken

Cardiothoracic surgery

Professor and chairman,
department of surgery,
University of Colorado
Denver, CO

Gerald B. Healy

Otorhinolaryngology

Otolaryngologist-in-chief,
Children's Hospital
Boston, MA



Board of Regents (continued)



Margaret F. Longo

*General surgery
Hot Springs, AR*

Jack W. McAninch
Urology
Professor of urology,
University of California-
San Francisco, chief of
urology, San Francisco
General Hospital
San Francisco, CA



Mary H. McGrath

Plastic surgery
Chief, department of plastic
surgery, Loyola University
Medical Center
Maywood, IL

John T. Preskitt
General surgery
Attending surgeon, Baylor
University Medical Center
Dallax, TX



Ronald E. Rosenthal

Orthopaedic surgery
Wayland, MA

Maurice J. Webb
Gynecology (oncology)
Gynecologic oncologist,
Mayo Clinic
Rochester, MN



Keeping current

What's new in *ACS Surgery: Principles and Practice*?

by Richard Lindsey, New York, NY

Following are highlights of recent additions to the online version of *ACS Surgery: Principles and Practice*, the practicing surgeon's first Web-based and only continuously updated surgical reference. Chapters may be viewed in their entirety by visiting the online version of *ACS Surgery: Principles and Practice* in the physician portion of the WebMD Web site at www.webmd.com.

XI. Surgical Techniques

17. Lymphatic Mapping and Sentinel Node Biopsy. Douglas Reintgen, MD, FACS; Fadi Haddad, MD; Solange Pendas, MD; Ni Ni Ku, MD; Claudia Berman, MD, FACS; Frank Glass, MD; Jane Messina, MD; and Charles Cox, MD, FACS.

The development of intraoperative lymphatic mapping and selective lymphadenectomy has made it possible to map the lymphatic flow from a primary tumor and to identify its so-called sentinel lymph node (SLN) in the regional basin. Integration of this technique, in association with detailed pathologic examination of the SLN, into the surgical treatment of melanoma and breast cancer offers the potential for more conservative operations that not only result in lower morbidity but also permit more accurate staging. Since the

publication of the initial version of this chapter in 1998, considerable additional data have become available that confirm the validity and utility of the technique and refine its practice. For instance, the evidence strongly argues that a combination approach yields better results than either radiocolloid or blue dye alone, and it is now clear that the blue dye can be injected as long as 16 to 24 hours after injection of the radiocolloid. In addition, alternative techniques for breast mapping have been developed that involve injection of the mapping agents into either the subareolar plexus or the skin above the tumor; for axillary mapping, these techniques seem to work as well as intraparenchymal injection.

XI. Surgical Techniques

9. Breast Procedures. Barbara L. Smith, MD, PhD, and Wiley W. Souba, MD, ScD, FACS.

Surgical procedures for the diagnosis and treatment of breast cancer continue to become less invasive and extensive while still allowing excellent control of local recurrence. For example, stereotactic core-needle biopsy performed with larger (that is, 11- to 14-gauge) needles currently misses only about 1 to 2 percent of lesions, a rate comparable to that associated with wire-localized open surgical biopsy. In addition, many surgeons now employ directional vacuum-assisted biopsy (DVAB), or mammotomy, a special diagnostic procedure for obtaining specimens for single or multiple breast lesions. This procedure is done on an outpatient basis and can generally be completed in one hour or less. DVAB is generally safe, has an acceptably low complication rate, and may diagnose nonpalpable breast lesions more effectively than stereotactic core-needle biopsy does. Suitable candidates for DVAB include patients with

continued on page 56

Monthly updates to the online version of *ACS Surgery: Principles and Practice* in the physician portion of the WebMD Web site, www.webmd.com, are also available quarterly through subscription to the *ACS Surgery* CD-ROM, which incorporates every online update from the previous three months and yearly through subscription to the annual hardcover edition of *ACS Surgery: Principles and Practice*, which incorporates every online update from the preceding year. To learn more, visit the *ACS Surgery: Principles and Practice* page on the ACS Web site, www.facs.org/members/acs_surgery.html.

Mr. Lindsey is managing editor of *ACS Surgery: Principles and Practice*, *WebMD Reference*, New York, NY.

Socioeconomic tips of the month

Filing for Medicare services

The end of the year is when surgical practices must decide whether to participate in or withdraw from the Medicare program. Surgeons who sign participation agreements agree to accept assignment for all covered services provided to Medicare patients in 2002. Participation agreements and the Medicare fee schedule for the coming year are distributed to surgeons annually by Part B carriers by December 1 of the current year.

Surgeons who choose to be participating providers are reimbursed under the Medicare fee schedule for amounts that are 5 percent higher than those of nonparticipating providers. Medicare sends participating physicians direct payment for 80 percent of the allowable, and their offices are only responsible for collecting the 20 percent copayment and applicable deductibles. In addition, Medicare automatically forwards claims to any Medigap insurer. Finally, participating physicians are listed in the *Medicare Participating Physician/Supplier Directory*.

On the other hand, surgeons who opt to be nonparticipating providers may bill 115 percent of the Medicare nonparticipating allowable. Please visit the ACS Division of Advocacy and Health Policy Web page for more detailed information (<http://www.facs.org/dept/hpa/medenroll.html>).

Important changes

Regardless of whether a surgeon chooses to participate, there are some changes in the way services provided to Medicare beneficiaries should be reported. Some changes surgeons should be aware of are as follows:

Updates for ICD-9-CM and the 2002 versions of *Current Procedural Terminology* (CPT) and HCPCS have been released.

ICD-9-CM was effective on October 1, 2001, and the 90-day grace period for incorporating the changes into claims ends December 31, 2001. The changes in the 2002 ICD-9-CM index and tabular lists can be downloaded at <http://www.cdc.gov/nchs/>

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Around the corner

December

- Medicare participation agreements due to Part B carriers by December 31, 2001.
- The 90-day implementation period for the 2002 ICD-9-CM codes ends December 31, 2001.

January

- Effective January 1, 2002
- 2002 Medicare fee schedule.
- First-quarter update to *Correct Coding Edits*.
- The 90-day implementation period for the 2002 CPT and HCPCS codes begins.
- ACS-sponsored basic coding workshop for surgeons at the Louisiana Chapter meeting on January 11. Contact Irene Dworakowski at 202/672-1507 or e-mail Idworakowski@facs.org for registration information.

[data/index02.pdf](#) and <http://www.cdc.gov/nchs/data/tabulr02.pdf>, respectively.

2002 CPT and HCPCS become effective January 1, 2002. The grace period for incorporating the changes is March 31, 2002. CPT may be purchased directly from the AMA publications Web site (<http://www.amasolutions.com>) or from a vendor. The Centers for Medicare & Medicaid Services (CMS) posts a zip file (ANHCP02.EXE) on its Web site, which contains the Level II alpha-numeric HCPCS procedure and modifier codes, their long and short descriptors, and applicable Medicare administrative, coverage, and pricing data in both Microsoft Excel and delimited text formats. The document *Hrrec02.doc* contains the legends to interpret the administrative and coverage policies. The product can be downloaded at <http://www.hcfa.gov/stats/pufiles.htm#alphanu>.

CMS has made changes in the HCPCS codes and modifiers to allow physicians to bill Medicare in order to get denials for secondary payors for noncovered items and services.

Codes A9190 (Personal comfort item, not covered by Medicare statute) and modifier -GX (Service not covered by Medicare) have been deleted.

The reimbursement status for code A9270 (Non-covered item or service) has been changed to "Not Valid for Medicare."

Beginning January 1, modifier -GY (Item or service statutorily non-covered) and modifier -GZ (Item or service not reasonable and necessary) should be appended to the code that describes the item or service provided to the beneficiary if a physician wants to indicate that the item or service is not covered or is considered a not reasonable and necessary service under Medicare. These modifiers cannot be used with any HCPCS codes that indicate the item or service is "Not Otherwise Classified."

Code Q3015 (Item or service statutorily noncovered, including benefit category exclusion) or code Q3016 (Item or service not reasonable and necessary) should be reported if no specific code describes the item or service provided to a Medicare beneficiary.

When a service is performed or an item is supplied that is not reasonable and necessary under the specific circumstances, the physician is responsible for notifying the beneficiary in writing by using the advance beneficiary notice (ABN). The provider or supplier should file the pertinent services or items on the claim with the -GA modifier (waiver of liability statement on file). The GA modifier must be used in conjunction with the Q3016 or GZ modifier, not instead or in place of them, with all Part B claims in which an ABN is given.

Also effective on January 1 is CMS's clarification of its coding guidelines for determining the appropriate primary ICD-9-CM diagnosis codes when reporting diagnostic test results (CMS Program Transmittal AB-01-114, September 26, 2001). This program memorandum applies to all diagnostic testing, including clinical laboratory tests, radiology services, pathology services, and medical services, such as electrocardiograms. Of course, diagnostic tests performed on surgical specimens (usually surgical pathology tests) are subject to the policy, but the procedure itself is not. The material that follows substantially simplifies the program memorandum by limiting it to situations in which the physician "ordered" the diagnostic test, performed it, and reports it to Medicare.

If a test confirms a tentative diagnosis, the phy-

sician reporting the test to Medicare should report the confirmed diagnosis. The signs or symptoms that prompted the test may be reported as additional diagnoses if they are not fully explained by or related to the confirmed diagnosis. The physician also may report unrelated and co-existing conditions. Incidental findings may be reported as secondary diagnoses (not the first diagnosis). When a test was done in the absence of signs or symptoms, screening (code V82.9) should be reported as the primary diagnosis code; any results of the test may be recorded as additional diagnoses. If the results of the diagnostic test are normal or nondiagnostic, then the reporting physician should report the sign(s) or symptom(s) that prompted the study. As always, diagnoses should be reported using the ICD-9-CM code that provides the highest degree of accuracy and completeness for the diagnosis resulting from a test or for the sign(s)/symptom(s) that prompted the ordering of the test.

The program memorandum also provides some information to physicians who send their patients or specimens to another facility for testing. Referring physicians are required to provide diagnostic information to the testing entity at the time a test is ordered. An order may be a written document signed by the treating physician/practitioner, which is hand-delivered, mailed, or faxed to the testing facility; a telephone call by the treating physician/practitioner or his/her office to the testing facility; or an e-mail by the treating physician/practitioner or his/her office to the testing facility. If the order is given by telephone, both the treating physician and the testing facility must document the telephone call in their respective copies of the beneficiary's medical records.

On the rare occasion when the interpreting physician does not have diagnostic information as to the reason for the test and the referring physician is unavailable to provide such information, it is appropriate to obtain the information directly from the patient or the patient's medical record. However, an attempt should be made to confirm any information obtained from the patient by contacting the referring physician.

The complete text of the program memorandum may be viewed at <http://www.hcfa.gov/pubforms/transmit/AB01144.pdf>. The latest ICD-9-CM coding guidelines can be downloaded at <http://www.cdc.gov/nchs/data/icdguide.pdf>. [Q]

Dr. Collicott named to ACS executive staff

ACS Executive Director Thomas R. Russell, MD, FACS, recently appointed Paul E. Collicott, MD, FACS, to the executive staff of the College. Dr. Collicott is the Director of the College's new Division of Member Services.

Dr. Collicott has been a Regent of the College since 1993, a member of the Board of Regents' Executive Committee since 1999, and a member of the Central Judiciary Committee since 1995 and its chair since 1998. Prior to his appointment at the College, he was in the private practice of vascular surgery in Lincoln, NE, and served as medical director of trauma services at Lincoln (NE) General Hospital (LGH). He was chairman of the department of trauma at LGH from 1981 to 1983, 1989 to 1995, and 1998 to 1999; he also served as chief of surgery at LGH from 1984 to 1985. In addition, Dr. Collicott was chief of the trauma division at Bryan/LGH Hospital in Lincoln.

A Fellow since 1977, Dr. Collicott has been active in a wide range of College activities. He was a member of the Board of Governors from 1992 to 1994, President of the Nebraska Chapter of the College from 1987 to 1990, and has been a member of the Advisory Council for Vascular Surgery from 1994 to the present.

Dr. Collicott was also a member of the ACS Committee on

Trauma (COT) from 1984 to 1993 and of the COT Executive Committee from 1984 to 1987. He was Chair of the Advanced Trauma Life Support® (ATLS®) Subcommittee of the Committee on Trauma from 1982 to 1988, and served as National ATLS® Course Director from 1980 to 1987 and as International ATLS® Course Director from 1987 to 1992. He continues to serve as one of the College's general surgery advisors to the Committee on Trauma.

In addition, Dr. Collicott served on the ACS CPT/RUC Review Committee from 1990 to 1998, and he has been a member of the ACS General Surgery Coding and Reimbursement Committee from 1998 to the present.

Dr. Collicott obtained his medical degree in 1966 from the University of Nebraska College of Medicine, Omaha. His internship took place at Lincoln General Hospital from 1966 to 1967. From 1967 to 1969, Dr. Collicott was a captain in the U.S. Air Force and chief of outpatient services at Malmstrom Air Force Base. He performed his residency at the University of Washington from 1969 to 1973. While in private practice Dr. Collicott held academic appointments at the University of Nebraska College of Medicine and Creighton University School of Medicine.

The author/contributor of many articles and book chapters, Dr. Collicott has served as



Dr. Collicott

an editorial consultant for *Trauma Quarterly*, the *Journal of Emergency Nursing*, the *Journal of Trauma*, and the *Journal of the American College of Surgeons*.

Among the numerous awards Dr. Collicott has received are the Trauma Achievement Award of the ACS Committee on Trauma (1982); the COT Service Award (1987); the ATLS® Meritorious Service Award (1988); the Surgeon's Award for Service to Safety—American College of Surgeons, American Association for the Surgery of Trauma, and the National Safety Council (1992); and the Meritorious Service Award of the Nebraska Medical Association (2001).

Take a look at the activities of the ACS Insurance Program

by Gay L. Vincent, CPA, Comptroller, Chicago, IL

The ACS Insurance Program has been in existence for 52 years. As of the plan year ending March 31, 2001, there were 6,612 members participating in the program and 13,512 certificates in force. Faced with an overall decline in program participation, members of the ACS Finance Committee joined the Insurance Trustees to assess the insurance plans and their benefit to the membership. The Insurance Trustees and Finance Committee members are excited about the recent changes they authorized to the program and hope members will take advantage of the benefits provided.

2001 Initiates

The ACS Insurance Program will provide to 2001 Initiates, at *no cost*, life, accidental death and dismemberment, and disability coverages for one year. There is absolutely no reason for a new Fellow to pass on this offer. You will be billed at the beginning of the second year for the appropriate premium. However, you are under no obligation to continue coverage. Obviously, we hope you will stay with the program, but it is your choice. If you are a 2001 Initiate, call the plan administrator at 800/433-1672 to sign up for the no-cost offer. The deadline for enrollment is December 31, 2001. There may be restrictions in some states due to insurance regulations.

Candidates/Associate Fellows

Beginning some time in 2002, Candidates and Associate Fellows will receive, at *no cost*, a \$50,000 life insurance policy for one full year. Each individual will receive a certificate of insurance as proof of coverage. You will not need to sign up for the insurance unless required by state law. You will be billed after one full year of coverage. However, you are under no obligation to continue your coverage. We hope to continue this offer each year for new Candidates and Associate Fellows as they join the College.

Life insurance plans

The life insurance plans have consistently been the most popular coverage. Those who participate will be very pleased with the upcoming reduction in premium. There are two plans available—the traditional term-life plan and the 10-year level term-life plan.

Under the traditional plan, the College has approved a premium discount for current participants. The discounts, authorized for the plan year beginning April 1, 2002, vary by age. The College hopes to continue discounts beyond the upcoming plan year, but it will depend on a year-to-year evaluation of the claim experience. Participants may want to take advantage of the savings

and purchase additional insurance under the new 10-year level term life plan.

Under the 10-year level term life plan, New York Life has proposed and the Trustees accepted a dramatic new premium schedule that will apply to all new applicants. While there are hundreds of companies offering term-life insurance, New York Life feels that the new rates developed exclusively for ACS will be among the lowest in the marketplace. The plan features include:

- The initial-period premiums are level and are guaranteed for 10 years.
- There are volume discounts. There are benefit amounts available up to \$2 million.
- Insured members under age 65 can apply for new entry-level rates at the end of the initial 10-year period. Those individuals who don't apply or who don't qualify for health reasons will be charged the current ACS traditional term level rates.
- The underwriting is expanded to include multiple risk categories (super-preferred, preferred, and standard).
- Coverage is renewable to age 75.

If you are looking for life insurance, include this product in your evaluation. We think you will be pleased.

Disability/health plans

The steepest decline in participation has been in disability and health coverage. The single most given reason is cost. The premiums are based on the actual claim experience of our group, which has not been favorable. As a result, the premium increases have been in the double digits for the past several years.

The Insurance Trustees, with the help of the Finance Committee, Insurance Advisors, New York Life, and USI Administrators, have been evaluating both products. Plan design changes were approved for both the Conventional and Cost Advantage Medical plans consisting of revised surgical schedules, use of a discount drug card, implementation of a Medicare carve-out feature, and additional deductible op-

tions to give additional premium rate alternatives. New applicants will be individually underwritten to determine the appropriate premium rate classification.

The Cost Advantage Medical Plan will include more PPO type provisions. With these changes and some additional administrative cost savings measures, we anticipate minimal premium increases for the next plan year beginning April 2002. Participants will receive new identification cards and details about the plan changes.

The disability coverage—premium rates and benefits—will remain unchanged. Recent administrative cost savings will help improve claim experience and preclude premium rate or benefit changes—at least for the near future.

Potential new products

The ACS Insurance Program continues to review and evaluate new products that may be of benefit to membership. Some of the new products recently introduced include critical illness, small employer health insurance, a Medicare supplement, and an MSA medical plan. More products, such as auto and homeowners, are being reviewed.

Contacts

Contact our plan administrator at 800/433-1672, or e-mail usia-ac@usia-c.com. You can also access the Insurance Program through the American College of Surgeons' Web site (www.facs.org)—select "Links to all College programs and activities from A to Z" on the home page, then under "I" select "Insurance Program."

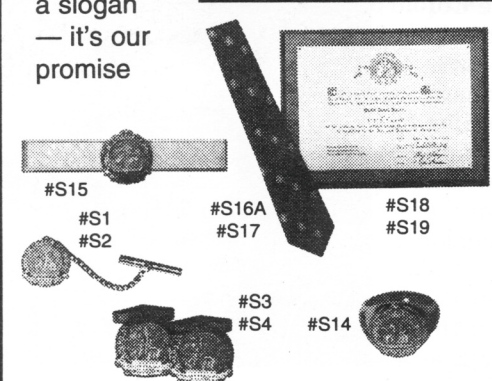
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#S8 Solid 14K Gold	\$150	NECKTIE			
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Working in the dark

by Wu Shaotung, San Francisco, CA

Bill Schecter likes to operate in the dark. That is, he doesn't know whether the hernia case under his hands belongs to a paying, insured client or one referred by Operation Access, the not-for-profit organization that serves the uninsured poor. To him, this is medical justice at its best; it meets the highest calling of the physician to treat those who cannot afford it—and to do it indiscriminately.

"I treat these patients like I treat every other patient. We see them in clinic. We schedule them. And everyone gets treated the same," he says. "It's really part of our medical ethic; it's what it's all about; it's part of what our job is."

The chief of general surgery at San Francisco General Hospital, William Schecter, MD, FACS, founded Operation Access in the early 1990s. At that time, the managed care industry ex-

ploded, and health care as it had been known imploded. Surgeons felt the squeeze. Between the entrance of the federal government into the health picture in the 1960s and managed care in the late 1980s, surgeons felt less incentive toward charity work. Dr. Schecter understands. "Everyone would like to be paid for the work that they do."

However, at the same time, these same forces were creating a new class of patients—the uninsured. While the indigent were being taken care of with Medicaid, the working poor were falling through huge cracks in the system. Today, there are at least 1 million newly uninsured individuals per year, Dr. Schecter says.

He has experienced the plight of these patients directly. "There were people dropping off the operating schedule. They had to decide between having an operation or eating." Of course, "food won out," he says.

Dr. Schecter called his friend Douglas Grey, MD, FACS, chief of thoracic and vascular surgery at Kaiser Permanente San Francisco Medical Center, and together they founded Operation Access. In eight years, the not-for-profit organization has averaged about 200 operations a year. Beginning with the two hospitals of the two founders and friends they recruited, Operation Access has grown to 13 hospitals in seven counties in Northern California and in-

volved hundreds of volunteer surgeons, anesthesiologists, nurses and hospital administrators.

Dr. Grey says Operation Access gives health care providers a chance to express the most basic instinct of health care givers. "It's a big gratification to serve the underserved. Some of us can travel around the world to save people, but many of us cannot take the time away from their families or their jobs." Yet the underserved are right in front of us, he says, "100 yards from any city hospital."

Beginning with low-risk, elective, general surgery, Schecter and Grey now have added specialists: "Now that the program is more mature, we've extended the repertoire and we now have ophthalmologists, orthopaedists, ear-nose-throat and reconstructive specialists." The surgeries are all outpatient and elective but often prevent the conditions from becoming catastrophic and allow patients to continue at their jobs.

At some hospitals, volunteers have made once-a-month Saturday surgery their donation. These medical professionals, unlike Dr. Schecter, who doesn't differentiate the charity cases, know exactly why they're there—to donate their skills. The scene, as captured in a recent *Los Angeles Times* front-page health feature, is celebratory; the work moves faster and more efficiently and the staff

Operation Access began in 1993. Currently, there are 225 medical volunteers, 60 community clinics, and 13 private hospitals that participate in public/private partnership to serve the uninsured in seven counties. Since its inception, Operation Access has saved the public health system approximately \$2.6 million. On average the organization serves between 200-250 uninsured clients per year.

genuinely enjoys what it is doing.

As Dr. Grey says, "It's win-win for everybody. It gets them back to the roots of why they went into medicine in the first place—for altruism. We get back to a social contract: Someone with a problem walks in, we fix it, he shakes hands, says thank you to the doctors and nurses, and walks out."

Operation Access takes the paperwork burden off the shoulders of physicians who want to help. Sometimes the gargantuan tasks of convincing hospital bureaucrats to join and of coordi-

nating the patients is enough to discourage a surgeon from contributing. But the organization takes care of these problems, and all a surgeon has to do is walk into the operating room and do what he or she knows and loves best.

While he likes to operate in the dark, Dr. Schechter is not blind. "We're not claiming that we're the solution to the health care situation. Our program is a temporary measure," he says. The light at the end of the tunnel is simple—health care for all. "My goal is for Operation Access to disappear—when ev-

eryone has health insurance, and we're no longer needed."

In the meantime, there is so much all surgeons can do.

For more information, please contact: Betty Hong, Executive Director, Operation Access, 1409 Sutter St., Suite 301, San Francisco, CA 94109, tel. 415/733-0051, fax 415/733-0019, e-mail operaccess@aol.com.

Ms. Shaotung (also known as Olivia Wu) is a freelance journalist specializing in health care and based in the San Francisco (CA) Bay area.

Clowes research award given

The George H.A. Clowes, Jr., MD, FACS, Memorial Research Career Development Award for 2002 was granted to Robert A. Montgomery, MD, DPhil, assistant professor of surgery, The Johns Hopkins University School of Medicine, Baltimore, MD, for his research project on strategies for silencing genes that potentiate ischemia reperfusion injury.

The purpose of the Clowes Award is to provide five years of

support for promising young surgical investigators. The award is sponsored by The Clowes Fund, Inc., of Indianapolis, IN, in the amount of \$40,000 for each of five years, beginning July 1, 2002.

Further information regarding the scholarships, fellowships, and awards offered by the College will be published in the January 2002 issue of *Bulletin* and appear on the College's Web site, www.facs.org.



Dr. Montgomery

2003 Travelling Fellowship available

The International Relations Committee of the American College of Surgeons announces the availability of a travelling fellowship, the Australia and New Zealand Chapter of the American College of Surgeons Travel-

ling Fellowship for the year 2003.

Complete details and the requirements are available upon request from the International Liaison Division, ACS, 633 N. Saint Clair St., Chicago, IL

60611-3211. They are also posted on the College's Web site, www.facs.org. The requirements will be published in their entirety in the January 2002 *Bulletin*.

No Second Opinion Needed.



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Contributions to the 2002 Surgical Forum are requested

Abstract deadline: March 1, 2002

Congress: October 6- 11, San Francisco, CA

The Committee for the Forum on Fundamental Surgical Problems invites young surgical investigators to submit abstracts to be considered for presentation during the Surgical Forum at the 2002 Clinical Congress in San Francisco, October 6-11. Preparation of the Forum program is achieved entirely through the review of abstracts of papers reporting original work performed by young surgical investigators. Abstracts that are accepted will appear in a supplement of the *Journal of the American College of Surgeons (JACS)*, a publication recognized by *Index Medicus*. In addition, authors whose abstracts are accepted for the program will be expected to publish their extended abstracts in the *Owen H. Wangenstein Surgical Forum Volume LIII*, which will be available in time for purchase at the Clinical Congress.

Abstracts received on time and in the prescribed form noted below are reviewed. *Abstracts not received on time or not **exactly** as prescribed will not be considered.* Please read and follow the regulations and specifications carefully. Proofread the abstracts; they cannot be resubmitted for corrections or alterations.

Abstracts are reviewed and selected by the Forum Committee, with each surgical specialty topic being reviewed by appropriate specialty members. General abstracts are graded by committee members most familiar with the abstract's designated category. Following the grading, the full committee meets to discuss the abstracts and select the work to be presented at the Congress. The committee's selections are final.

Notice of acceptance or rejection will be mailed to the principal author of each abstract by May 1. The acceptance notice designates the session where the paper is to be presented and provides information regarding presentation and the

preparation of the extended abstract for publication in the *Surgical Forum Volume LIII*.

Please do not call the Forum office; the staff is unable to acknowledge receipt of abstracts, is not permitted to alter abstracts in any manner, and cannot release the results of the Forum Committee's selections.

Regulations for submitting an abstract

The Owen H. Wangenstein Forum on Fundamental Surgical Problems requires that any investigator who wishes research to be considered for presentation must comply with the instructions concerning the preparation and submission of abstracts.

1. Abstracts are due in the Surgical Forum office no later than March 1, 2002. Submission of an abstract signifies the intent of its principal and associated authors to present the paper at the Surgical Forum, if it is accepted.

2. The abstract must present original research, with the understanding that the research will be presented for the first time at the Forum. *The principal author is responsible for making certain that the paper submitted contains no material that has been published elsewhere prior to presentation at the Surgical Forum. In addition, the principal author is responsible for informing the Forum Committee if the abstract or the paper has been or is to be presented in total or in part at any regional or national meeting prior to the Clinical Congress of the American College of Surgeons; this is cause for exclusion of the paper from the Forum.* Discretionary consideration will be given to papers for which abstracts may have been published outside the United States and Canada; principal authors are nonetheless bound to inform the Committee of

such abstract publication *via e-mail* at surgforum@facs.org.

3. The principal (first-named) author must be a young surgical investigator. Older, established surgeons may be included as co-authors, but not as the principal author of an abstract. Please limit the number of co-authors to nine persons.

4. An author may submit only two abstracts as the principal author, and no more than one may be selected for presentation. Any principal author submitting two abstracts should submit an e-mail stating the titles, categories, and institution affiliation to: surgforum@facs.org.

5. *The principal author may not be changed after an abstract is submitted, nor may co-authors be added or deleted.*

6. Each abstract should be a concise report summarizing work done and in progress. The title of the abstract should be brief, but long enough to identify clearly the nature of the study. The body of the abstract should clearly state the reason for doing the study and include a brief description of methods, the exact results obtained, and the conclusions reached.

It is essential that the abstract present objective data and an accurate analysis of the results. It must be clear that sufficient evidence has been found to support the conclusions. Vague descriptions and promises to present additional information will result in almost certain rejection.

Abstracts should not include unnecessary material such as historical reference, controversial discussion, bibliographies, and review of the literature. Abstracts should be prepared and edited carefully.

7. The extended abstract submitted for publication in the *Surgical Forum Volume LIII* must accurately reflect the significant substance and conclusions represented in the initial *abstract* accepted by the Surgical Forum Committee. If changes in the substance or conclusions in the *abstract* would be necessary for publication of the extended abstract, the submission should be withdrawn by the author(s).

Specifications for the abstract

1. Abstracts for the Surgical Forum Program will be accepted **ONLY** via Internet submission at: <http://web.facs.org/surgicalforum/abstract.cfm>. Submit a complete version of the abstract and

one blinded version bearing only the title and the body of the abstract (omit identifying author information). The complete and blinded versions should be submitted as separate files. Submitted abstracts must contain the **ENTIRE** title in the file name and indicate which file is the blinded version at the end of the filename, i.e., "(title of abstract)blindvers.wpd" (or 'blindvers.doc' etc.).

2. Each abstract must be confined to **one side of one 8-1/2" x 11" page, contain no more than 30 lines of text and no more than 250 words**. This includes title, text, authors, and mailing information.

3. Allow a **1-1/2" margin** on the left side, and a **1/2" margin** on all other sides of the page.

4. At the top of the page, the full title of the abstract should be typed with initial capitals. The title should be single-spaced.

5. All abstracts must be designated for one of the categories listed below. The author must choose the category most appropriate for his or her abstract and type the category in the upper right hand margin of the abstract. The categories are: Alimentary (includes liver, pancreas, biliary tract); Cardiac; Thoracic; Critical Care (includes metabolism, infection, nutrition, blood, endocrine); Surgical Oncology and Associated Immunology; Transplantation and Associated Immunology; Gynecology and Obstetrics; Neurological Surgery; Ophthalmology; Orthopaedic Surgery; Otorhinolaryngology; Pediatric Surgery; Plastic Surgery (includes wound healing, burns); Quality, Outcomes, and Cost; Reproductive Biology and Related Endocrinology; Urology; and Vascular Surgery.

The author may, in addition, designate a second category for the abstract. The second category may be selected from the list above, or may be created by the author. Designation of a second category for any abstract is at the author's discretion.

6. Leave a double space after the title. The body of the abstract must be **double-spaced**. Use a 12-point font or larger, and no more than 16 characters per inch. Organize the abstract with the following headings (non-indented): **INTRODUCTION** (include the reason or rationale for the study, as well as the hypothesis being tested or objective of the study); **METHODS** (in-

clude a brief notation of the statistical methods employed); RESULTS (tables should be single spaced, using the same font as in the body of the abstract; graphs or figures must be clearly legible and contain legends or notations no smaller than 20 characters per inch); and CONCLUSIONS.

7. Leave a double space after the body of the abstract and list the full names and all academic degrees of all authors, followed by the institution from which the work originates. List the institution first, followed by the mailing address and daytime telephone number of the *principal author* or designated contact person in sufficient detail to ensure prompt delivery of communication. The mailing address should be accurate for correspondence in *May*. If the principal author anticipates an address or institutional change

during that time, provide a mailing address and/or contact person that will ensure prompt receipt of communications from the Surgical Forum Committee. Single-spacing should be used for this information. Changes in authorship will not be accepted. PLEASE NOTE: *Only one institution will be published. Contributors (financial, material, laboratory space, etc.) to the research will not be published.*

8. Abstracts are to be submitted no later than **March 1, 2002**. For further instructions or clarification, please forward your e-mail request to: surgforum@facs.org.

9. Abstracts submitted via fax transmittal are unacceptable.

10. Abstracts are **not** to be submitted to the chairman or to members of the Surgical Forum Committee.

Scientific contributions sought for 2002 Clinical Congress

Motion Picture videotape and form due by March 1, 2002

The College will again be reviewing and showing videotapes at the 2002 Clinical Congress. Only videotapes in the 3/4-inch U-matic or 1/2-inch Super VHS format (NTSC) will be considered. Authors of medical motion pictures who wish to have their work presented during the 2002 Clinical Congress in San Francisco (October 6-11) should submit the videotape and specific information about the videotape and the author on a special Videotape Information Form to the College's Committee on Medical Motion Pictures by March 1, 2002. The form is available from the Committee on Medical Motion Pictures, Attn: Gay Lynn Dykman, American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611-3211. The print of the videotape for committee review must be received by March 1, 2002.

Papers Sessions abstracts due by March 1

Papers Sessions are planned for the 88th annual Clinical Congress, October 6-11, 2002, in San Francisco. These sessions are restricted to clinical work that has not been presented previously or published elsewhere. (Basic laboratory research should be submitted to the Committee for the Forum on Fundamental Surgical Problems.) *The Committee on Papers will consider only those abstracts of which the principal author or a co-author is a Fellow of the College.* Authors should adhere to the following instructions:

1. The abstract should provide adequate information and objective data to evaluate the abstract properly.

2. The abstract must be limited to one 8-1/2" x 11" page, with a left margin of 1-1/2". (It is permissible to single-space the abstract.)

3. At the top of the page, the full title of the abstract and the full names and academic degrees of all authors must be listed.

4. At the bottom of the page, a footnote should be included to provide the principal author's mailing address, telephone number, e-mail, and fax number and, where pertinent, medical school affiliation and other institutions from which the work originates.

5. The original and one copy of the abstract should be submitted.

6. Photographs *should not* accompany the abstract.

7. The deadline for the receipt of abstracts is March 1, 2002. They should be mailed to the Committee on Papers, American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611-3211.

Quality and a balanced program are the committee's chief criteria for evaluating the ab-

stracts received. However, because of the competitiveness of this portion of the scientific program, it is unlikely that an author would be selected to present his or her work in two successive years.

Scientific exhibits due March 1, 2002

Applications for participation in the scientific exhibits at the 2002 Clinical Congress will be available in January from the Committee on Scientific Exhibits, 633 N. Saint Clair St., Chicago, IL 60611-3211. The deadline for receipt of completed applications is March 1, 2002.

There is no charge to scientific exhibitors for display space. They must, however, pay their own shipping and assembly costs. The exhibit area will be open Monday through Thursday, October 7-10, 2002.

DOUBLE-DIGIT PREMIUM HIKES, from page 20

year for \$1 million/\$3 million of coverage. Physicians in several states, such as Pennsylvania, West Virginia, Florida, and Mississippi have been especially hard hit, and physicians in other locations will soon suffer a similar fate, unless they are able to persuade their state legislators to enact major reform.

Fundamental change needed

The current crisis will not be contained by palliative measures. We need a fundamental change in the way we deal with medical injuries. For many years, I have favored a no-fault approach (patient compensation insurance). This system has worked well in other countries, such as Denmark, Finland, New Zealand, and Sweden, for many years and has been effective in cases involving newborns with severe neurological damage in Virginia and Florida. It also has also been effective in the U.S. for many years as applied to a government-sponsored program dealing with vaccine injuries. Further, it is the same approach being advocated for those affected by the September 11 tragedy.

Physicians cannot continue to shoulder the burden of a system that:

- Compensates fewer than one in eight patients who are negligently injured.
- Is based on the determination of fault where professionals often disagree.
- Can entail five to seven years of litigation before an injured patient receives any compensation.
- Generates devastating emotional damage to the physician and his or her family even when they are later acquitted by the court.
- Impedes the development of a comprehensive patient safety program because the consequences of self-reporting injuries or near misses may result in prolonged litigation.
- Takes 60 percent of the premiums paid by physicians and puts them into the hands of lawyers.

It is time for a change!

□

This article was generated through the efforts of the Regents' Committee on Patient Safety and Professional Liability. Members of the committee believe that this and other articles published in the *Bulletin* will stimulate thought and possible action on a wider spectrum of issues related to patient safety and professional liability.



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Fellows and facts

The 2001 Bucy Award was presented to **George J. Dohrmann, MD, PhD, FACS**, in recognition of his national and international efforts in neurosurgical education. Dr. Dohrmann is a neurosurgeon at the University of Chicago Medical Center and a member of the faculty of the Brain Research Institute at the University of Chicago, IL. The Bucy Award is presented annually by the national Bucy Committee and honors Paul C. Bucy, MD, FACS.

The members of the American Academy of Otolaryngology-Head and Neck Surgery (AAO-HNS) elected **Jonas T. Johnson, MD, FACS**, to serve as president of the organization and its foundation for the 2002-2003 term. Dr. Johnson is professor of otolaryngology at the University of Pittsburgh School of Medicine in Pittsburgh, PA.

Alan Koslow, MD, FACS, is one of six people nationwide who were presented with the March of Dimes' Distinguished Volunteer Award this year at a ceremony attended by President Bush. Dr. Koslow, a vascular surgeon in Des Moines, IA, was recognized for being one of 10 students who organized the first March of Dimes walk in 1971 and for his continuing commitment to the organization over the last 30 years. He has directed the public affairs committee of the Iowa chapter of the March of Dimes for the past four years and is chair-elect of the chapter.

On January 15, 2002, **Michael D. Maves, MD, FACS**, will begin serving as the executive vice-president and chief executive officer of the American Medical Association. Dr. Maves served as executive vice-president of the American Academy of Otolaryngology-Head and Neck Surgery

from 1994 to 1999. Most recently, he directed the Consumer Healthcare Products Association in Washington, DC. Dr. Maves served on the ACS Board of Governors from 1995 to 2000, and has been an active participant in many medical and surgical organizations throughout his professional career.

Eugene N. Myers, MD, FACS, professor and eye and ear foundation chair at the University of Pittsburgh School of Medicine, received the American Laryngological Association (ALA) Award and the deRoaldes Award at the annual meeting of the ALA earlier this year. The ALA Award has been presented annually since 1987 to recognize an individual who has contributed significantly to laryngology. The deRoaldes Award was established in 1907 and is presented to acknowledge outstanding accomplishments in the specialty.

REPORT OF THE EXECUTIVE DIRECTOR, from page 34

ing conditions of surgical residents. There are a multitude of other topics this division could effectively evaluate in the future.

Finally, with new leadership in the Division of Member Services, I anticipate a vast array of potential opportunities will unfold. Some of those possibilities include new programs, such as courses on association management, improved instruction in practice management, and efforts to relieve some of the regulatory burdens of practice. I also believe we will see renewed efforts to reach out to and influence the international surgical community, thereby making the College a more effective and global organization.

Preparedness

Following the recent Clinical Congress in New Orleans, I can assure you that one of the highest priorities of the College is addressing the broad issue of bioterrorism. Again, there are real opportunities for developing educational activities that will allow surgeons to become more active and participatory in their local communities with respect to future terrorism and the ability to provide appropriate and timely responses. As surgeons, we, along with the entire community of trauma physicians and institutions, are uniquely capable of assisting in this process. □

Chapter news

by Rhonda Peebles, Chapter Services Manager, Division of Member Services

To report your chapter's news, contact Rhonda Peebles toll-free at 888/857-7545, or via e-mail at rpeebles@facs.org.

Michigan Chapter conducts 48th annual meeting

During its 48th annual meeting, May 10-12, the Michigan Chapter conducted its Resident Surgeons Competition with Barbara L. Bass, MD, FACS, then-Chair of the Board of Governors and current Regent, leading the judging of 37 abstracts. The 2001 competition produced seven winners. Also during the annual meeting, the chapter's Young Surgeons Issues Committee conducted its first Young Surgeons Forum. During this symposium, the chapter's young surgeons agreed to review and report on state legislative issues that affect surgeons and their patients. They also established small, ad hoc committees to examine several topics: liability immunities for uncompensated care, issues related to certified registered nurse anesthetists, prompt payment by insurers, the state trauma system, and the chapter's annual scientific education programs. Finally, the chapter elected its officers for 2001-2002, who are as follows: Drs. Verne L. Hoshal, President; Farouck Obeid, President-Elect; Donald Scholton, Secretary; and Cheryl Wesen, Treasurer.

Massachusetts Chapter identifies strategies for future

The Massachusetts Chapter engaged its officers, councilors, Governors, and past-presidents in a strategic planning session this August. The special working session was convened to address: (1) a nearly 30 percent decline in membership and revenue; (2) the perceived need to establish a closer, more collaborative relationship with the College; and (3) the responses and results of the chapter's Town Meeting Program, which involved meetings with Fellows that took place at individual hospitals. After completing its initial deliberations, the chapter developed strategies to respond to the following areas of concern:

- Education: The chapter plans to develop an



Tennessee Chapter, left to right: Calvin Morgan Jr., MD, FACS, Governor; Timothy Fabian, MD, FACS, Governor; David N. Walters, MD, FACS, President; Martin Croce, MD, FACS, President-Elect; Laura Witherspoon, MD, FACS, Secretary-Treasurer; K.C. Jonas, MD, FACS, Governor; Wanda Johnson, Executive Director; Ken Sharp, MD, FACS, Immediate Past-President and Governor; and George Eckles, MD, FACS, Vice-President.

education program for residents and young surgeons that will address disability insurance, employment opportunities, contract negotiation skills, and other practice-related topics. The chapter also intends to survey program directors for additional potential topics and to seek opportunities to partner with the College on enhanced and timely education programs.

- Socioeconomics: The chapter will meet with the Governor of the Commonwealth to develop an agenda for the future and will continue a limited public relations/education program.

- Communications: The chapter will continue the Town Meeting Program and will attempt to assume responsibility of the Massachusetts Committee on Applicants of the College and will seek opportunities to participate in the selection of the College's leadership. (See related story, p. 10.)

Tennessee Chapter conducts annual meeting

The Tennessee Chapter conducted its annual meeting August 17 to 19 at Fall Creek Falls State Park (see photo, this page). During the three-day event, the trauma and cancer committees met, chapter business activities were conducted, the chapter's new Web site was unveiled (<http://>

www.tnacs.org). John R. Potts III, MD, FACS, from Houston, TX, served as the visiting professor, and three resident paper competitions were conducted. Taking first place in the paper competitions were:

- Trauma: Michael Kelly, MD,* University of Tennessee, "Effects of selective A2a activation during resuscitation from severe chest trauma with either crystalloid or colloid."

- Basic Science: Ben Zarzaur Jr, MD,* University of Tennessee, "Intravenous feeding (IV-TPN) increases inflammation following gut ischemia/reperfusion (gI/R)."

- Clinical Science: Henry Kaufman, MD,* University of Tennessee, "Stereotactic breast biopsy—a study of first core samples."

The Tennessee Chapter's 50th annual meeting will take place July 27-28, 2002.

West Virginia Chapter conducts Surgery Update 2001

The West Virginia Chapter (WVC) conducted its Surgery Update 2001 September 21-22. The education program was hosted by the West Virginia University department of surgery (WVU-DOS) in Morgantown. The theme for the conference was The Latest in Minimally Invasive Surgical Techniques; 12 speakers addressed the topic during the course of the event. Presiding over the education program were: David W. McFadden, MD, FACS, chairman of WVU-DOS, and Michael Szwerc, MD, FACS, assistant professor of surgery, as conference directors; Mark Talamini, MD, FACS, from The Johns Hopkins University, Baltimore, MD, as the visiting professor; Kyle Fort, MD, FACS, WVC President, and R. Samuel Oliver, MD, FACS, WVC President-Elect. (See photo, this page).

On September 22, the West Virginia Committee on Trauma (WV-COT) Resident Paper Competition took place, and David Kappel, MD, FACS, the Chair of the WV-COT, served as the presiding officer of that event.

Special notice

In 2002, two important education programs are being combined. These education programs include



West Virginia Chapter, left to right: Stephen McNatt, MD, FACS, assistant professor of surgery; visiting professor Dr. Talamini; Dr. McFadden; Dr. Fort; Dr. Szwerc; and Dr. Oliver.

the Young Surgeons Representatives Annual Meeting and the Chapter Leadership Conference. A preliminary schedule for the combined event includes:

May 15: Half-day education program for chapter administrators and executive directors.

May 16: Full-day education program for chapter officers and chapter administrators; joint reception and dinner for young surgeons, chapter officers, and chapter administrators.

May 17: Full-day education program for young surgeons, chapter officers, and chapter administrators, including plenary sessions and break-out workshops.

May 18: Half-day education program for young surgeons.

Chapter anniversaries

Month	Chapter	Years
November	Arkansas	49
	Chile	50
	Florida	49
	Indiana	50
	Kentucky	49
	Michigan	50
	Nebraska	50
	Bronx, New York	50
	Central Pennsylvania	49
	Southwest Pennsylvania	49
December	Argentina	48
	Missouri	35

*Denotes participant in the Candidate Group.

KEEPING CURRENT, from page 39

nonpalpable but mammographically visible clusters of suspicious calcifications, those with well-defined masses that are likely to be benign, and those with suspicious masses.

VIII. Evaluation of Common Clinical Problems

6. Intestinal Obstruction. W. Scott Helton, MD, FACS.

In as many as 90 percent of patients with adhesive partial small bowel obstruction, nonoperative surgery will lead to resolution of the obstruction. How to identify those who require operation remains an issue. Several studies have reported that recording the arrival of a contrast agent in the right colon within a specified period can be a highly reliable predictor of whether nonoperative therapy is likely to succeed. In addition, several studies, though not in perfect agreement, have yielded results suggesting that administration of contrast agents may in itself be therapeutic for adhesive small bowel obstruction in some settings. One such

study found meglumine diatrizoate to promote resolution of obstruction (though not to affect the need for laparotomy); however, another reported no therapeutic effect (and no complications). That some investigators have reported positive findings and none to date have reported significant complications argues that giving 100 ml of meglumine diatrizoate to patients with adhesive small bowel obstruction is a reasonable choice. If this step accelerates the resolution of adhesive small bowel obstruction and ileus, it may also shorten hospital stay and thereby reduce the cost of care.

Looking ahead

New chapters scheduled to appear as online updates to *ACS Surgery: Principles and Practice* in the first part of 2002 include Laparoscopic Donor Nephrectomy, by Stephen Bartlett, MD, FACS, and Stephen Jacobs, MD, FACS, and Open Esophageal Procedures, by Richard Finley, MD, FACS, and John Yee, MD. □

2002 Young Surgical Investigators' Conference

March 8-10, 2002

Lansdowne Resort
Conference Center
Leesburg, VA

Sponsored by the Surgical Research
and Education Committee of
the American College of Surgeons

The Surgical Research and Education Committee of the American College of Surgeons has organized the Sixth Biennial Young Surgical Investigators' Conference to assist surgeon-scientists who are entering the process of obtaining extramural, peer-reviewed grant support for their work. The goal of these conferences, held with staff members of the National Institutes of Health (NIH) in attendance, is to introduce young surgeons to the process, the content, the style, and the people involved in successful grant-writing and interactions with the NIH.

The program will include intensive exposure to:

- NIH programs and policies
- Information from NIH Institutes
- What programs are best and available for your research project and how to apply
- Workshops in hypothesis testing, methodology, background, and preliminary results
- Grant-writing strategies
- Mock study sections reviewing model grants

The program and registration form are available online at <http://www.facs.org/dept/serd/srec/youngsurg.html>. For further information, contact Ms. Donna Coulombe, Education and Surgical Services Dept., American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611; phone 312/202-5488; fax 312/202-5013; e-mail dcoulombe@facs.org

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The *Journal* page

Message from the Editor

by Seymour I. Schwartz, MD, FACS, Rochester, NY

The January issue of the *Journal of the American College of Surgeons* will usher in a new year and also lead to a consideration of the past.

During the year 2002, the 250th anniversary of the opening of the Pennsylvania Hospital, the first hospital to function in the current United States, will occur. One hundred years ago, at the 1902 meeting of the American Surgical Association, Rudolph Matas, MD, FACS, presented his monumental paper describing "An Operation for the Radical Cure of Aneurism Based on Arteriorraphy."

Also at that meeting, "A New Method of Pyloroplasty" was presented by J. M. T. Finney, MD, FACS, who would become the first President of the American College of Surgeons. Fifty years ago, in the January issue of *Surgery, Gynecology & Ob-*

stetrics, Charles G. Child, MD, and associates reported the first case in which an unobstructed portal vein was deliberately resected during a pancreaticoduodenectomy. Also in the same issue Rene Leriche concluded that aortography had limited diagnostic applicability, and should be used only in a patient in whom resection or reconstruction of a vascular lesion was to be considered.

Which article in the January 2002 issue of the *Journal of the American College of Surgeons* will be quoted 50 years hence is unpredictable.

Dr. Schwartz is Distinguished Alumni Professor, University of Rochester (NY) School of Medicine and Dentistry. He is also Editor-in-Chief of the Journal of the American College of Surgeons and a Past-President of the College.

INTRODUCTORY ABSTRACT from the January lead article

The American Urological Association Lecture: Evolution of an Academic Medical Center to an Academic Health System. David B Skinner, MD, FACS. From Weill Medical College of Cornell University, New York, NY.

During the course of more than a decade, the problems encountered by New York-Cornell Medical Center and Columbia-Presbyterian Medical Center have been addressed individually and suc-

cessfully. The merger of these two institutions and the creation of a broad metropolitan-wide health system facilitated and enhanced the success of these efforts and led to a gradual switch in emphasis from that of the individual hospital and practitioner to the successes that can be achieved by a large number of academic and community physicians and hospitals working together for a common purpose.

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